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ABSTRACT

This material is for the use of educators involved in the Pennsylvania Alcohol-Highway Safety Program. The 16-hour course of instruction has been prepared to inform both teachers and students of the Commonwealth of Pennsylvania's DUI (Driving under the Influence) Safe Driving School. It concentrates on the development of knowledge, and the changing of attitudes for all DUI offenders arrested in the Commonwealth. A Curriculum Guide, as well as Judicial, Law Enforcement, Counseling and Rehabilitation, and Local Officials Manuals, are included. (Author/JLL)

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CURRICULUM AND INSTRUCTOR'S GUIDE

For The

Commonwealth Of Pennsylvania's Alcohol Highway Safety Program

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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PREFACE

This Instructors Guide for the Pennsylvania DUI Safe Driving School is being prepared by International Alcohol and Mental Health Associates, Inc. under the aegis of the City of Philadelphia's Coordinating Office on Drug and Alcohol Abuse Programs, Project Manager, Nicholas Piccone, Ed.D. Contract No. 6-3113 entitled "Curriculum and Instructors Guide for Use with Persons Arrested for Driving While Intoxicated (DWI)."

This Instructors Guide was prepared for The Governor's Council on Drug and Alcohol Abuse and the Pennsylvania Department of Transportation in conjunction with the National Highway Traffic Safety Administration, Contract No. AL 76-10-4.

Project Staff responsible for the preparation of this Instructors Guide were: Pascal Scoles, D.S.W., Project Director; Eric W. Fine, M.D., M.R.C. Psych., Medical Director; Michael J. Mulligan, M.Ed., Clinical Psychologist; and Ms. Mary Miller, Administrative Assistant, International Alcohol and Mental Health Associates, Inc.

FOREWORD

The material enclosed in this Instructors Guide is for use by educators involved in the Pennsylvania Alcohol-Highway Safety Program. The 16 hour course of instruction has been prepared to inform both teachers and students of the Commonwealth of Pennsylvania's DUI Safe Driving School. In particular, it concentrates on the development of knowledge and hopefully, the changing of attitudes for all DUI offenders arrested in the Commonwealth.

Each of the eight two-hour classes within the Instructors Guide is divided into two parts: lesson plans and course content. The lesson plans are basically an instructor's guide to the material that will be covered within each class. It accentuates the kind of information needed to effectively manage a given lesson plan. The course content consists of summary material regarding each of the various lesson plans. ***THE COURSE CONTENT WAS NOT INTENDED TO BE READ VERBATIM FROM THE INSTRUCTORS GUIDE***, although the course content is structured with audio-visual aids and instructor's notes which indicate a suggested classroom format. The Pennsylvania Alcohol-Highway Safety Program's objective is to provide the instructor with the fundamental facts about alcohol, alcoholism, and highway safety. We anticipate that each class and county within the Commonwealth vary, in relation to the amount of information one should give to accomplish the DUI objectives. One hopes that the instructor will "pick and choose" those parts of the course content that he feels needs to be stressed in order to make the appropriate impact. Each lesson plan is detailed and very explicit regarding the program objectives. The instructor should make every attempt to use the lesson plan in as flexible a manner as possible. The detailed manner in which the lesson plans are presented is not intended to inhibit instructional method. We hope that the Instructors Guide will provide the educator with enough instructional method to allow him to be innovative and adaptive to the needs of a given DUI Safe Driving Class.

It is important to realize that the recommended Pennsylvania DUI Safe Driving School's 16 hour course in general can be used quite flexibly. Within a given community certain lesson plans can be collapsed into four hour sessions, some can be expanded into six hour sessions. The objectives that are specified within the lesson plans are more important than whether or not the course is collapsed into five, six, eight, or ten sessions. ***Remember***, our objectives are (1) to disseminate knowledge regarding alcohol, alcoholism, and highway safety; and (2) to influence attitudes and indirectly alcohol-related behaviors. For example, Lesson Plan VI and VII, ***Alcoholism and Family Disruption*** and ***Alcoholism and Me*** can logically be collapsed into one, three or four hour session or can logically continue from one week to the next involving both the husband and wife in their discussions.

All of the training aids. i.e., films, filmstrips, student readings, etc. are noted in the Appendix entitled "Resource Materials." Please note that this material can be purchased directly from the organizations mentioned and if funds are available, you should purchase that material which you consider pertinent to ***your*** DUI Safe Driving School. If the resource material is not available from the information provided, be aware of the fact that instructors should check with other sources at his or her disposal for training aids which may be available through a variety of different suppliers.

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RATIONALE

The DUI Safe Driving School is a statewide attempt to help drinking drivers arrested for Driving Under the Influence understand the relationship of alcohol consumption to highway safety and to personalize how alcohol can contribute to a further deterioration of one's family, economic and social functioning. Course content has been selected to provide students opportunities to explore the meaning of alcohol consumption in relation to themselves and at the same time present background concepts that provide reasonable grounding for the student to rationally reflect on his own drinking and driving behavior.

OBJECTIVES

The specific objectives for each lesson plan will individualize each student's learning. The instructor provides the objectives so that the student understands what he will learn and be accountable for in the DUI course. The objectives are stated clearly in the beginning of each lesson plan. They range from the simple learning of facts and concepts and demonstrated understanding of them to the application of knowledge in new situations.

LEARNING MATERIALS

Supplementary readings for enrichment or further study are distributed at the end of each lesson plan. This material is used for homework assignments between each class. One hopes that pre-learning will enhance the student's understanding of the course objectives.

REVISION

Since the educational material is based on current knowledge, improvements in instructional material will have to be reviewed ***yearly*** so that the course content maintains its relevancy to the Alcohol-Highway Safety field. Also, instructors may find an area in which his student is experiencing unusual difficulty and, as a result, decide to incorporate more explanatory items.

INSTRUCTOR TRAINING

The Instructor of the Pennsylvania DUI Educational Safe Driving School is required to have knowledge and skills. Knowledge about alcohol use, alcoholism, highway safety, and psycho-educational processes. Instructors also need skills in the application and practice of the principles of group dynamics.

Since all of the skills and knowledge are considered essential to an effective educational program, the trainee/instructor must possess these skills within his own life experiences, either through in-service training programs or traditional academic settings. If not, an effective training workshop for all instructors must be conducted under the auspices of an appropriate training institution within the Commonwealth. In general, training for DUI Instructors is important since the Alcohol-Highway Safety field does not, at the present time, concentrate on the broad base perspective of the Pennsylvania Alcohol-Highway Safety Program.

One hopes that the trainee/instructor will master the basic skills and begin to broaden his/her perspective and discover techniques from other psycho-educational literature that will widen his repertoire of skills and in turn be a more effective facilitator.

COURSE EVALUATION

For the purposes of evaluation, two instruments, the DUI Knowledge Attitude Inventory (KI) and the Drinking and Driving Inventory (OS) will be utilized to measure the effectiveness of the DUI Safe Driving School. (See Appendix 1)

The KI is a 40-item multiple choice test lasting ***15 to 25 minutes*** and designed primarily to measure knowledge of the effects of alcohol on driving and its relationship to subsequent accidents. The inventory was inductively derived from the findings of numerous studies, and was developed by utilizing internal-consistency-item-analysis techniques from a pool of 152 items.

The OS is a 38-item true and false type attitude scale lasting ***10 minutes*** designed to measure attitudes toward drinking and driving.

Both pre- and post-data collection are ***mandatory***. All teachers must read the instructions prior to administering the KI or OS.

COSTS OF EDUCATIONAL PROGRAM

Although the overall costs of a fully comprehensive DUI Countermeasures Program might appear high for new programs, one should approach this issue with two special considerations in mind.

First, the bulk of ***new services*** should be largely ***self-supporting***, and ***second***, the potential benefit to the citizens by the "ripple effect" could be profound in human and budgetary terms also.

It is especially pertinent to the issue of DUI that these persons are typically at the early stages of alcoholism and extremely high risk candidates for later, more serious consequences of their condition. There is voluminous evidence available that suggests the types of costs that counties absorb, directly and indirectly, from the alcoholic persons residing in the county. Some of these costs are defined in the terms of Business (average 22 more absences per year than non-alcoholics, double the accident rate), Jail (up to 50% of the inhabitants may be alcoholic persons), Social Welfare (1/4 to 1/3 of assistance to families with dependent children funds are paid to households with alcohol problems), Drug Abuse (abnormally high rates of juvenile drug abuse in homes with parental alcoholism), Mental Health (1/3 to 1/2 of admissions to state and county hospitals are typically alcohol-related), Fire (up to 80% of fire-related deaths related to alcohol abuse), Health (suicide, accidents, general ill health and excessive hospital usage typify the extremes associated with the alcoholic population).

EDUCATIONAL THEORY FOR THE DUI SAFE DRIVING SCHOOL

It is obvious to all educators that teaching has become a highly refined art, and education an intrinsically structured institution.[1] The application of this art, through an understanding of maturation and learning, is the means by which changes occur in students. Maturation is a process through which a behavior sequence develops by means of physical changes taking place after birth, regardless of intervening social experiences.[2] Learning, on the other hand, is a change in a living individual which is not heralded by his genetic inheritance; it may be a change in behavior, insights, perception, motivation, or a combination of these.

The DUI Safe Driving School, which provides sixteen hours of class instruction via weekly sessions of two hours each, attempts to accomplish for its students the following major goals: (1) increase in knowledge regarding alcohol, alcoholism and highway safety; and (2) change in attitudes regarding driving under the influence of alcohol or controlled substances (DUI).

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[1] DiVesta, F.J. and G.G. Thompson. ***Educational Psychology: Instruction and Behavioral Change***. New York: Appleton-Century-Crofts, Inc., 1970, p.1.

[2] Hilgard, E. and G. Bower. ***Theories of Learning***. New York: Appleton-Century-Crofts, Inc., 1966, p.4.

The rationale for the DUI Safe Driving School is based on an assumption that an individual who consumes alcohol, and in particular "drinks and drives," has a fundamentally positive attitude toward alcohol consumption. In general, he perceives drinking as beneficial, and uses positive phrases such as "It tastes good," "It takes the hurt out of my bones," "I have more fun when I drink," "It helps me forget about my worries," etc. Surprisingly, and yet in keeping with cognitive dissonance theory,[3] few, if any, of the deleterious effects of drinking alcohol are discussed by the offender (student). The admittance to self and others that one's drinking behavior has negative and at times grave consequences for oneself would create for the individual internal conflicts, and would perhaps result in a decrease in their drinking. Therefore, an individual who drinks, continues to do so primarily because he continues to maintain a positive position of thinking, feeling, and acting as if alcohol were conducive to his good health. Furthermore, he drinks (defined as an individual who drinks and actively desires to continue his drinking at some level) via an elaborate ritual, the intention of which is to deny to himself in some manner the introjection of negative data concerning alcohol use. His denial of the negative aspects of alcohol is accomplished through an elaborate cognitive-emotional process. This process promotes the "goodness" of alcohol (acts, events, situations, feelings, thoughts, etc.) and does not allow the negative to be felt or known, through the utilization of such mechanisms as repression, denial, suppression, projection, selective perception, reaction formation, forgetting, etc. ***In summation, alcohol consumers accentuate the positive and ignore the negative regarding their alcohol use.***

Applying cognitive dissonance theory to the phenomenon described above, the DUI safe driving classes should emphasize the negative aspects of drinking and driving. To facilitate change in drinking behavior, one must first create dissonance –i.e., conflict–in the individual's attitudes and beliefs regarding his drinking behavior. One can assume that first offenders arrested for DUI will attend class feeling generally that their drinking behavior is positive. Most offenders feel that the fact that they were arrested is more important than their alcohol consumption. This persistent and, in reality, rigid thinking and behavior must first be challenged in order to begin the process of change. This can be accomplished by presenting data that attest to the negative qualities of drinking alcohol. If this is done through the utilization of information (valid, reliable, and believable), a possible conflict situation (dissonance) will result within the individual, i.e., two sets of contradictory information about the same issue (alcohol).

However, because of the offenders rigid thinking and behavior, the individual may not incorporate the new data, since inconsistent and dissonant behavior creates conflict–which is, of necessity, threatening and anxiety-provoking. Innumerable psychological studies attest to the fact that people in general develop defense mechanisms to avoid feeling anxious.[4] Knowing this occurs, one

[3] Festinger, L. ***A Theory of Cognitive Dissonance.*** California: Stanford University Press, 1957; Festinger, L. ***Conflict, Decision and Dissonance.*** California: Stanford University Press, 1964.

[4] Spielberger, C. ***Anxiety and Behavior.*** New York: Academic Press, 1965; Fenichel, O. ***The Psychoanalytic Theory of Neurosis.*** New York: W.W. Norton and Co., 1945; Levitt, E. ***The Psychology of Anxiety.*** New York: Bobbs-Merrill Co., 1967.

must attempt to introduce these dissonant facts about alcohol in the context of a warm, supportive and accepting climate which will help to reduce the level of threat. In the DUI classes, an attempt must be made to motivate the individual by creating tension through cognitive dissonance while maintaining a non-threatening external class climate to facilitate and support new thinking and behavior. Since change involves both cognitive and emotional processes, it is important that an individual's emotional component, his "feelings" regarding his drinking behavior, as well as his cognition, be utilized and integrated into the change process.[5]

CLASSROOM STRATEGIES

In general, information negatively biased toward drinking, and driving and drinking, is presented. Several films such as "Emotions and Your Driving," Highway Highball," "To Your Health," and "Point Zero Eight," etc. are used to present the debilitative aspects of drinking and driving. The necessary impact is provided, as these films illustrate auto accidents where drinking drivers are directly or indirectly responsible. All films are used as stimuli for lectures and discussions. Factual information is presented in a straight-forward manner, using data from the best available resource literature on alcohol, alcoholism, and highway safety.

The role of an effective teacher should be to lead students in such a manner that he helps them formulate and solve problems. To accomplish this, the teacher should have a rich, extensive background in alcoholism, highway safety, and group dynamics. He should be alert to habitual attitudes and outlooks students are developing, and his classroom atmosphere should foster maximum growth. This means that he should be able to judge which attitudes or insights are conducive to continued growth and which are detrimental. He should also have some understanding of students as persons and, to some degree, what is actually going on in the life space of those whom he teaches.

Of critical importance throughout the eight class sessions is the instructor's behavior and attitudes. The instructor's task is to create a class atmosphere that will effectively reduce anxiety resulting from the dissonance caused by the new information received from the films, group discussions, and lectures. It is, therefore, important that the instructor display openness, acceptance, and a willingness to share and become involved with his students. Many students view the DUI classes as part of a punitive alternative to prosecution, and it is necessary for the instructor to be non-judgmental and non-evaluative. In fact, the instructor should behave in a manner that attests to the individual student's self-worth. In essence, the instructor's behavior should help the student to reduce his anxiety while remaining open and accepting of new learnings. To effect this learning environment, small group techniques are used to further promote a positive learning climate.[6]

[5]Rogers, C. ***On Becoming A Person.*** Boston: Houghton-Mifflin Co., 1961; Postman, N. and C. Weingartner. ***Teaching As A Subversive Activity.*** New York: Delta Publishing Co., 1969.

[6]Golembiewski, R. and A. Blumberg, Eds. ***Sensitivity Training and the Laboratory Approach.*** Illinois: Peacock Publishers, 1970; Bradford, W., J. Gibb and K. Benne. ***T-Group Therapy and the Laboratory Method.*** New York: John Wiley and Sons, Inc., 1964.

For the present DUI school, "a positive learning climate" is defined as one that minimizes student anxiety and stimulates student learning capability. These objectives are met by using group processes to (1) promote participation, and therefore allow the individual to take an active part in his own learning; (2) create an atmosphere in which individuals can freely share ***feelings*** as well as ***thoughts***, and thus release tension constructively; and (3) rally group support for individual participation and involvement in the class.

Since reading assignments will be given a week prior to a class session (pre-learning preparation), and since most of what happens within the class will be structured around the use of group technique to facilitate learning, it would seem important to outline what kind of group experience will be used and how it will fit into the overall process of the course.

GROUP DYNAMICS AND CLASSROOM ACTIVITY

The use of group process to enhance learning stems from two distinct historical influences: John Dewey's emphasis on social aspects of learning and Kurt Lewin's empirical research on group action techniques.[7] Within the past 15-20 years, small group techniques have taken an influential place within the field of education.[8]

Each class will begin with the teacher discussing with the students the major points of conflict and agreement each student has experienced through his or her specific assignments. The teacher (facilitator) will in turn outline on the blackboard the major areas of conflict and agreement. He will also, where appropriate, add his own feelings about the specific assignments. If the students seem to have missed any major points, the teacher should feel free to add ideas which facilitate reflective learning.

The facilitator (teacher) will begin by stating that any member is free to express his or her feelings, but such expression must make some connection to the topic area under discussion for that particular class.

The facilitator may ask the group members to talk directly to the person addressed and to stay with the here-and-now as much as possible. The facilitator should state emphatically that what goes on in the class remain confidential so that an atmosphere of trust can prevail. If a student feels uncomfortable about a given topic area, that student should feel free to express his feelings and state why he feels uncomfortable. Above all, the facilitator's role is to stress the positive aspects of learning and to state directly that learning consists of the acquisition of knowledge–which provides us with inconsistencies, which produce a desire for consistency, which thrusts the individual to seek personal harmony. During the process of seeking this new harmonious synthesis, it is ***not uncommon*** for us to make mistakes.

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[7]Schmuck, R. and P. Schmuck. ***Group Process in the Classroom.*** Iowa: W.C. Brown, 1971, p. 15.

[8]***Ibid.***, pp. 16-17.

Carl Rogers notes that much of the success of a group can depend on the facilitator. Students will get involved only as the facilitator gets involved. One cannot stay aloof or detached and expect the student to become open and involved.[9]

As the leader of the group, the facilitator, where indicated, should become more direct; he should reveal his own feeling in an attempt to facilitate the overall process, and he should constantly strive to bring a vital balance between freedom and course objectives.[10]

The practice oriented principles described in this section of the instructors guide are broadly applicable to almost any classroom structure irrespective of content area. The quality of instruction, in the final analysis is determined not by what is written but rather the consummate skill of the teacher who creatively blends his personality style with the course content. No two instructors will approach the principles of group dynamics in exactly the same way but one hopes that the process will encourage ingenuity and creativity.

The group process objectives are a re-education experience based upon sound psychosocial principles. ***Remember***, our purpose is to examine and evaluate in terms of societal acceptability, effectiveness, efficiency, and lawfulness what are the underlying motives and needs which stimulate the DUI offender to drink and drive and in turn violate the law. Through group discussions members are encouraged to learn and experience different approaches to their current lifestyle. By comparing, discussing and sharing, the group tends to support and aid those individual members who are seeking to help themselves function in society.

Pre-planning for Group Meetings

To a great extent each instructor should have already reviewed before the first session some basic information about the group.

(1) Age range

(2) Cultural background

(3) Neighborhood of student

(4) Needs of individuals as reported in Diagnostic Interview*

(5) Level of alcohol use or abuse*

(6) Specialized experiences of members

*See Appendix E, ***Counseling and Rehabilitation Manual***

[9]Rogers, C. ***Carl Rogers on Encounter Groups.*** New York: Harper and Row, 1970.

[10]Schmuck, R. and P. Schmuck, ***op. cit.***, pp. 26-43.

(7) Students currently involved in treatment

(8) Etc., etc.

There are many other informational issues the teacher should learn, the above list is not inclusive. As the instructor gains experience, he will be able to enlarge upon different points of information about the class.

The biggest mistake a group facilitator (teacher) can make, in the beginning, is to feel or act in such a way that he conveys the idea that he is not bound by the same standards as the group. Whatever the facilitator asks of the group, he must also ask of himself. The atmosphere of the group can be enhanced or inhibited by the way in which the instructor provides an example.

The instructor, before the class, should arrange the room in which the session is to be held. Every student should be able to see every other member of the class. A circle or roundtable form of arrangement seems to work out very well. Also, the instructor should have all material or equipment he intends to use for a particular class in the room. This includes such items as the projector, film, articles, audio-visual aids, etc. The purpose behind this preparation is to insure that the session won't be interrupted by a frantic search for some instructional material that you should have in the classroom.

Partly due to the nature of the arrest and the offender's involvement with the Judiciary, many students may feel defensive about the DUI Safe Driving School and may attempt, out of their anxiety, to:

(1) ***Put the Instructor on the Spot***

Some students may ask the teacher embarrassing questions in order to put the instructor on the defensive. A good approach to this situation would be to ask the class why the group feels they have to act in such a manner. This approach brings the issue back to the group for discussion, it curtails unnecessary acting out beyond a reasonable point, it focuses the group on some of its anger toward the school and/or the arrest process and finally, it lets the group know that you are aware of their frustrations and anger.

(2) ***Safe Talk***

Many groups may play a waiting game in an attempt to control the discussion. For example, let's get the instructor to talk about himself or let's talk about the weather or go off on tangents.

A good approach to this is to respond briefly to the questions and refocus the group discussion to whatever is reflected in your lesson plan. For example, in Lesson Plan V dealing with the American alcoholic, it is important to stress American drinking practices and the drinking driver, ***not*** to go off on a tangent about how drunk Americans are in general.

(3) ***DUI Offenders Pre-plan their Discussions***

Some students derive security from planning ahead what they want to say. Pre-planning doesn't automatically imply a lack of honesty. In general, the instructor should try and relate the offenders pre-planned discussion to the topic area. If not, the group may become bored and uninterested in what is transpiring.

(4) ***Boredom***

Remember one does not have to talk in order to express his interest in the discussion. The instructor should state in a relaxed, comfortable style that an individual or the group seems bored with the topic discussion and the teacher was wondering why the person or group feels that way.

Being aware of the above issues, let us begin the group discussion. Start out with an informal circle, allow each member to introduce himself to the group, don't forget to introduce yourself. The instructor then should introduce the lesson plan; ***be brief, informal, factual, and informative.*** During the lecture part of the session you are a speechmaker. During the group discussions, there is no place for long-winded, sermonizing oration or lecturing. Try not to make the mistake of talking when you should be listening. It takes two different kinds of skills to lecture and be a facilitator, try not to confuse the two concepts.

Following the lecture, the instructor should state the purpose of the group discussion. For example, in Lesson Plan II ask the questions related to the film, ***Alcohol and the Human Body.*** Also, each member should know how long the group will discuss the topic. The group facilitator should give at least five minutes notice before terminating; at termination, summarize the highlights of the group discussion, comment on interesting issues raised during the session, suggest the need for further exploration of certain topics in subsequent classes, and give recognition to group and individual members for participation and for special contributions. When the class session has ended, you may have an opportunity to reinforce desirable behaviors by encouraging members to test and apply their new learning outside the group, to further evaluate themselves and their world, to encourage members to think about related issues, etc.

Finally, it is the responsibility of the instructor to:

(1) Guard against unrelated tangents;

(2) Give credit to individuals for all contributions;

(3) Point out related issues which the class might explore;

(4) Allow diverse points of view;

(5) Encourage all students to participate;

(6) Warmly discourage "soap box" oration;

(7) Patiently help a member express himself;

(8) Summarize appropriate issues being fair to each point of view.

To reiterate, end each class with a summary and a preview of the next lesson plan. Always comment on hand out material and what you expect for the next class session.

LESSON PLAN I

(Two Hour Course Instruction)

A. *SPECIFIC TOPIC:* Introduction to Pennsylvania Alcohol-Highway Safety Program.

B. *GENERAL OBJECTIVE:* To introduce the student to the goals and objectives of the Commonwealth of Pennsylvania's Alcohol Countermeasures Program from arrest to treatment.

C. *SPECIFIC OBJECTIVES:*

(1) To describe the scope of the Commonwealth's program now being implemented to control the drinking driving problem;

(2) To establish each of the subject areas to be covered in the DUI Safe Driving School;

(3) To know the Commonwealth of Pennsylvania's law regarding the DUI violation;

(4) To objectify by each student, the twelve hours prior to their arrest;

(5) To pre-test knowledge and attitudes of DUI offenders;

(6) To reduce anxiety and negative emotions about class attendance and develop a trust building relationship with group members.

D. *COURSE CONTENT:* See attached lecture.

E. *METHODS AND MATERIALS:*

(1) *METHODS:* Lecture on course content and small group discussion (60 minutes); Pre-test Data Collection: KI (25 minutes), OS (20 minutes), and 12 Hours Prior to Arrest Form (15 minutes).

(2) *MATERIALS:*

(a) 12 Hours Prior to Arrest Forms
(b) Knowledge Attitude Inventory (KI)
(c) Driving Opinion Survey (OS)
(d) ***ABC's of Drinking and Driving*** (Student Reading)
(e) ***Pennsylvania Manual for Drivers*** (Student Reading)

F. ***DISCUSSION AND REVIEW QUESTIONS:***

All questions are to be generated from the instructor/student interaction regarding the Pennsylvania Alcohol-Highway Safety Program.

LESSON PLAN I – COURSE CONTENT

INTRODUCTION TO PENNSYLVANIA ALCOHOL-HIGHWAY SAFETY PROGRAM

INSTRUCTOR'S NOTE:

Before introducing the Pennsylvania Program, ***you must*** administer the KI, OS, and 12 Hours Prior to Arrest Form. This should take approximately sixty (60) minutes.

The remainder of the first session is the Pennsylvania Alcohol-Highway Safety Program. The instructor should begin Lesson Plan I by reviewing the attached flowchart which graphically demonstrates the Pennsylvania Countermeasures System developed for all DUI arrests. Emphasis should be on the various component parts of the program; Police, the Judiciary, Counseling and Rehabilitation Personnel, and the Educational Safe Driving School. Devote a significant amount of time reviewing in a brief fashion all of the educational lesson plans and the Commonwealth of Pennsylvania's Motor Vehicle Code as it relates to the DUI arrest.

The ***Judge*** is responsible for the DUI offender's current attendance at the Safe Driving School. Based on a review of an individual offender's record, which at times includes prior Motor Vehicle offenses, prior arrest records, and the counseling and rehabilitation diagnostic evaluation. The Judge will determine the seriousness of the DUI offense and indicate his/her decision.

The ***police officer*** who arrests the DUI offender is primarily responsible for the detection and apprehension of individuals who violate the Commonwealth's Motor Vehicle Code.

Approximately 50-70% of DUI offenders, following their ***diagnostic evaluation*** and their Safe Driving School experience will be assigned for further rehabilitation in one of the local counseling and rehabilitation programs. Approximately 30% of the DUI offenders are social drinkers and their rehabilitation terminates with the DUI Safe Driving School Program.

INSTRUCTOR'S NOTE:

It is not uncommon for students to complain about the police arrest process or to question the diagnostic evaluation. ***Remember***, your purpose is to try and reduce anxiety and negative emotions regarding the total Alcohol-Highway Safety Program. The best approach to this is to be firm but accepting of their complaints and to reiterate that legal questions should be discussed with the offender's attorney.

The Commonwealth of Pennsylvania Motor Vehicle Code – Related to Drinking and Driving (Act 81):

There are a number of provisions within the Motor Vehicle Code which comprise the Commonwealth's policy addressing the problem of drinking and driving. The following is a summary of the various provisions.

Section 3731 – defines driving under the influence of alcohol or controlled substances as a serious traffic offense. The use of alcohol, controlled substances, or the combination of either to a degree which renders a person incapable of safe driving is prohibited and classified as a third degree misdemeanor. The authorized use of such cannot be used as a defense (i.e., prescription usage); and an officer may arrest if he has reason to suspect alcohol or drug influence.

Section 1532 (a) (2) and Section 1532 (b) (2) – stipulates ***penalties*** to a maximum of $2,500 for violation and conviction under Section 3731. On the ***first offense*** (conviction) the department ***must*** suspend the license for ***six months***. If there is a ***second offense*** within three years, the department ***must*** revoke the license for ***one year***.

Section 1540 (a) – requires in cases of mandatory revocation (as provided above) that the court or the district attorney require surrender of the license, and the commencement date for suspension or revocation begins on the date the license is received by the court or the department.

Section 1534 – allows that Accelerated Rehabilitative Disposition (ARD) be offered for violations of Section 1532, however use of ARD must be considered in determining subsequent suspensions (Section 1539 (c)).

Section 1542 (a) and (b) – defines "***habitual offenders.***" Basically, if a person was convicted of driving under the influence three times within a five year period, they would be classified as an habitual offender and subject to an automatic five year revocation.

The very specific provisions dealing with driving under the influence are found in Section 1547, 1548 and 1549.

Provisions in those sections are outlined below.

Section 1547 – Chemical Test to Determine Amount of Alcohol:

- Consent to alcohol blood level testing is implicit in holding a license.
- Tests must be administered by physician, technician, or trained police officer.

- If a person refuses to submit to test, the test will not be given but there will be an automatic six months suspension for refusing and an automatic one year suspension for a second refusal.

- Police officer must notify the person of consequences of refusal.

- Results of the test are admissable as evidence in summary or criminal proceedings.

- If tests show:

  .05 or less = the finding will conclude that the person is not under influence and there will be no charge under 3731 (1) (2).

  .06 – .09 = there will be no conclusive finding, but in combination with other evidence, it could be proven that there was alcohol influence.

  .10 or more = there is a presumption of influence.

- If a person is unable to give enough breath for test, blood may be taken. Same provisions on test results as evidence and for refusals apply for blood tests as for breath tests.

- Person shall be permitted to have the test administered by their personal physician and results are admissable.

- Person may request test if involved in an accident and request is to be honored when possible.

- Persons administering tests and hospitals employing such persons are immune from civil liability.

Section 1548 – Post Conviction Examination for Driving Under Influence:

- Requires the court to conduct a pre-sentencing examination to determine if the person needs treatment for alcohol or drug abuse. If the exam indicates a treatment need then the court may order outpatient treatment or commitment to a facility approved by The Governor's Council on Drug and Alcohol Abuse. The exam is carried under provisions of the MH/MR Act of 1966.

- The pre-sentencing exam applies only to second or subsequent offenses within five years.
- The person may be examined by a doctor of their choice and results may be presented to the court.
- The court may also, upon petition, review the order of commitment.

Section 1549 (b) – Establishment of Schools requires the Department of Transportation in conjunction with The Governor's Council on Drug and Alcohol Abuse to establish and maintain an educational course on the problems of alcohol and driving throughout the Commonwealth.

PENNSYLVANIA ALCOHOL-HIGHWAY SAFETY PROGRAM (PAHSP)

FLOWCHART

I. LAW ENFORCEMENT SECTOR

IA. Arrest Process

II. JUDICIAL SECTOR

IIA. District Attorney Pre-Trial Screening

IIB. Trial Proceedings

IIC. Post-Diagnostic Court Ruling

III. REHABILITATION SECTOR

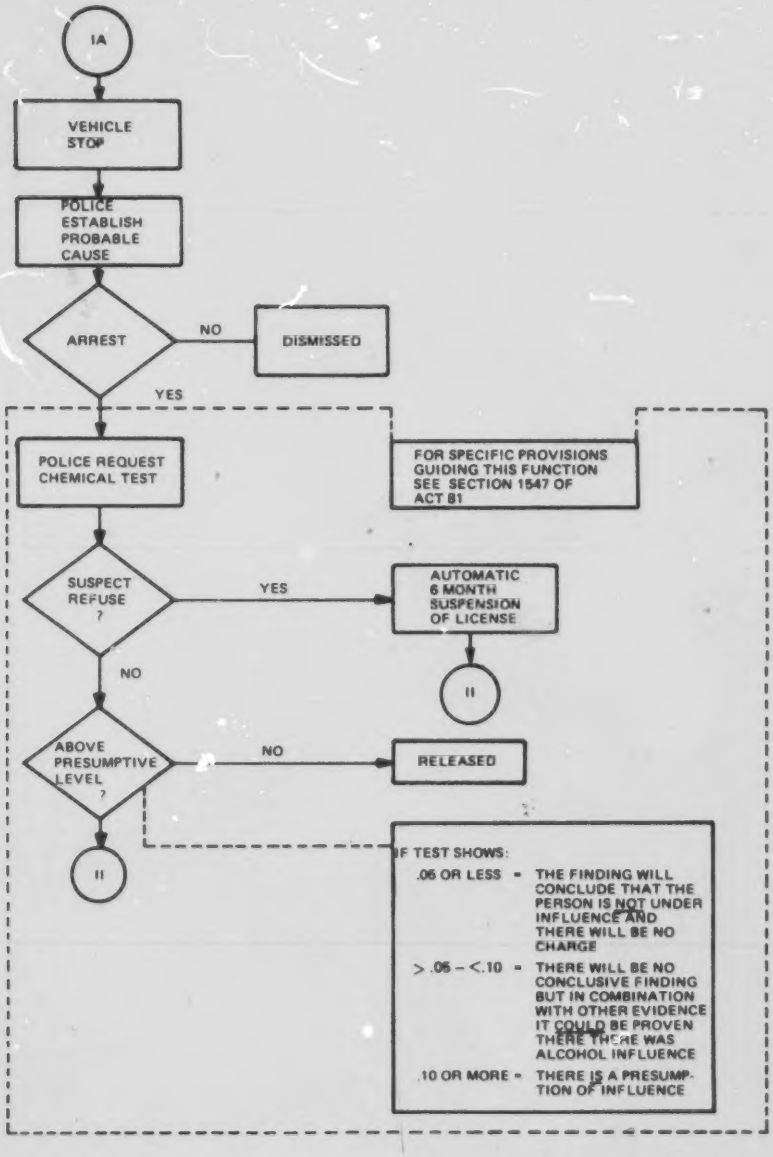
IIIA. Diagnostic Evaluation

IIIB. Psycho-Medical Treatment

IIIC. PAHSP Safe Driving School

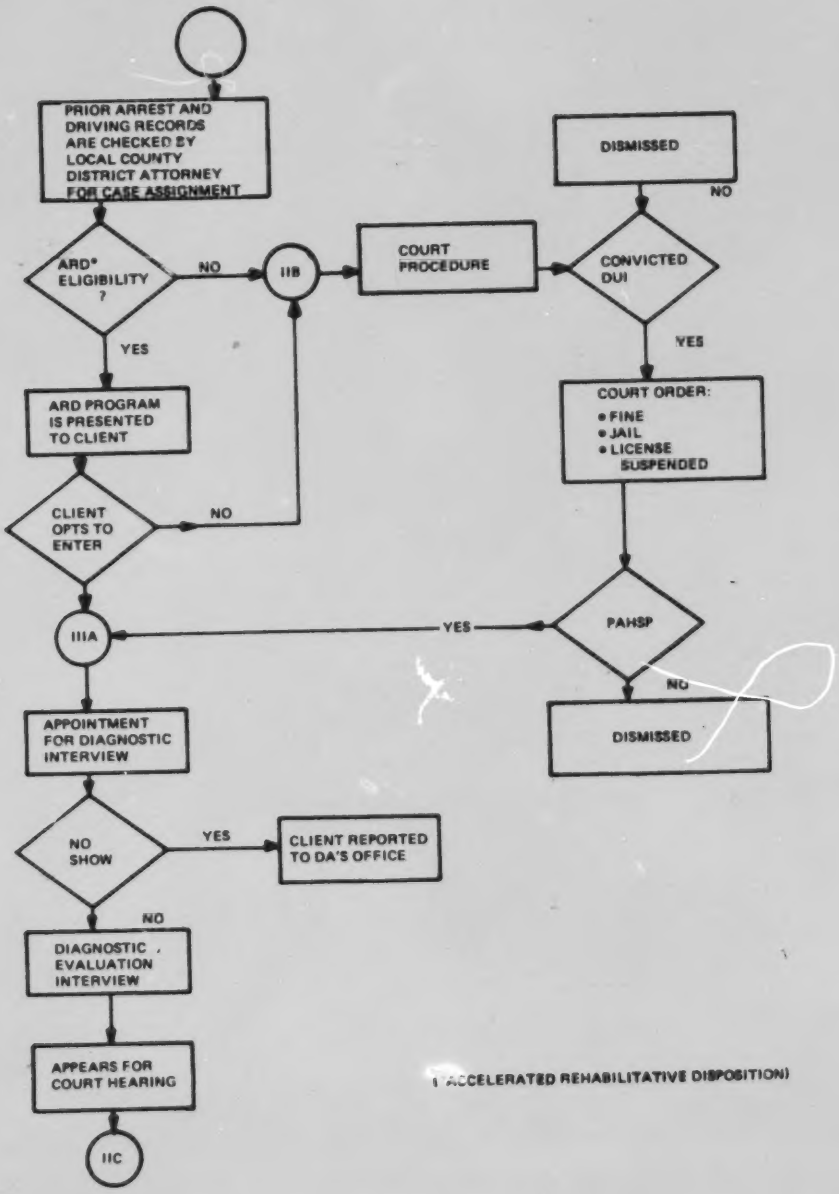
PAHSP – FLOWCHART (1)

I. LAW ENFORCEMENT SECTOR


IA
VEHICLE STOP
POLICE ESTABLISH PROBABLE CAUSE
ARREST
NO
DISMISSED
YES
POLICE REQUEST CHEMICAL TEST
FOR SPECIFIC PROVISIONS GUIDING THIS FUNCTION SEE SECTION 1547 OF ACT 81
SUSPECT REFUSE ?
YES
AUTOMATIC 6 MONTH SUSPENSION OF LICENSE
II
NO
ABOVE PRESUMPTIVE LEVEL ?
NO
RELEASED
II
IF TEST SHOWS:
.06 OR LESS = THE FINDING WILL CONCLUDE THAT THE PERSON IS NOT UNDER INFLUENCE AND THERE WILL BE NO CHARGE
> .05 – < .10 = THERE WILL BE NO CONCLUSIVE FINDING BUT IN COMBINATION WITH OTHER EVIDENCE IT COULD BE PROVEN THERE THERE WAS ALCOHOL INFLUENCE
.10 OR MORE = THERE IS A PRESUMPTION OF INFLUENCE

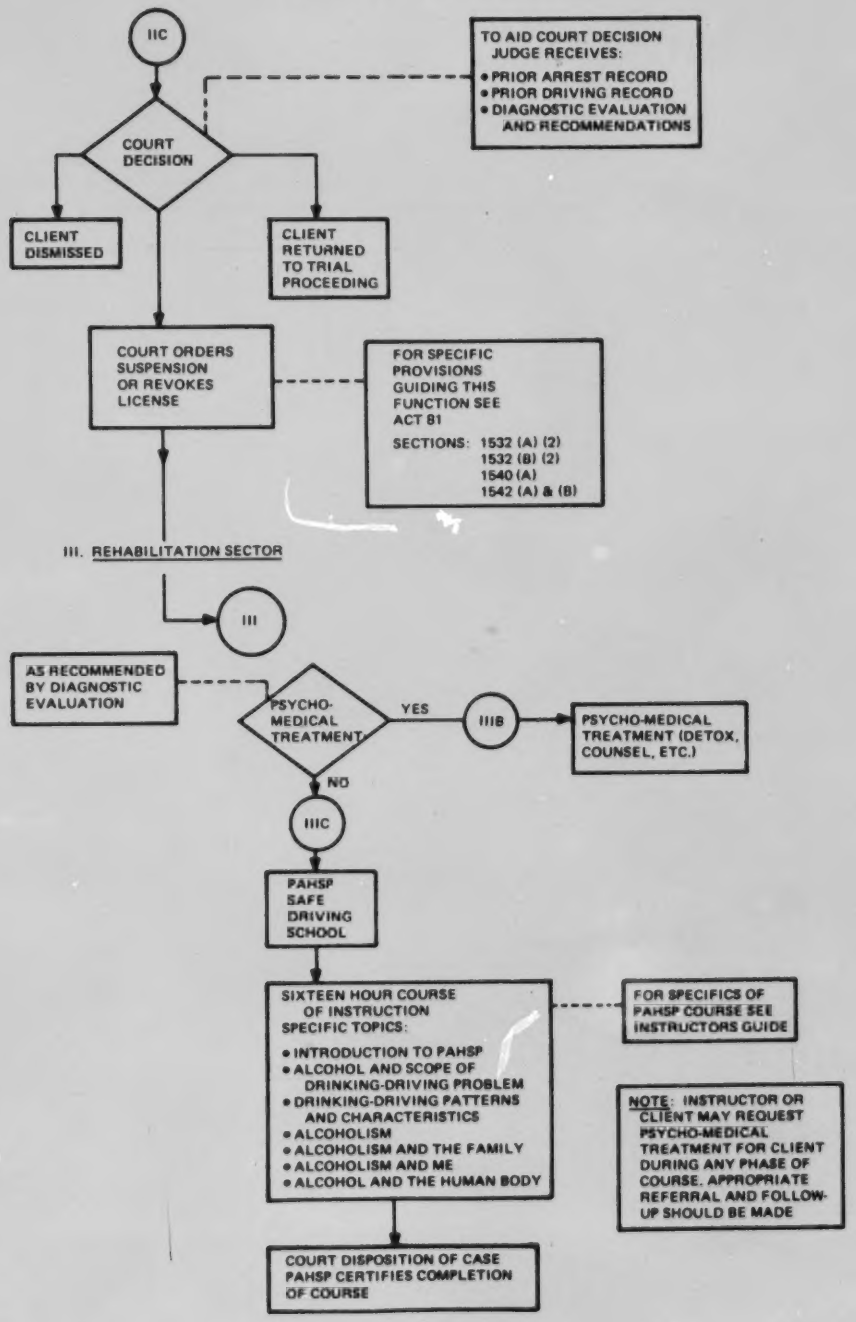
PAHSP – FLOWCHART (2)

II. JUDICIAL SECTOR



* ACCELERATED REHABILITATIVE DISPOSITION)

PAHSP – FLOWCHART (3)


IIC
TO AID COURT DECISION JUDGE RECEIVES:
• PRIOR ARREST RECORD
• PRIOR DRIVING RECORD
• DIAGNOSTIC EVALUATION AND RECOMMENDATIONS
COURT DECISION
CLIENT DISMISSED
CLIENT RETURNED TO TRIAL PROCEEDING
COURT ORDERS SUSPENSION OR REVOKES LICENSE
FOR SPECIFIC PROVISIONS GUIDING THIS FUNCTION SEE ACT 81
SECTIONS: 1532 (A) (2)
1532 (B) (2)
1540 (A)
1542 (A) & (B)
III. REHABILITATION SECTOR
III
AS RECOMMENDED BY DIAGNOSTIC EVALUATION
PSYCHO-MEDICAL TREATMENT
YES
IIIB
PSYCHO-MEDICAL TREATMENT (DETOX, COUNSEL, ETC.)
NO
IIIC
PAHSP SAFE DRIVING SCHOOL
SIXTEEN HOUR COURSE OF INSTRUCTION SPECIFIC TOPICS:
• INTRODUCTION TO PAHSP
• ALCOHOL AND SCOPE OF DRINKING-DRIVING PROBLEM
• DRINKING-DRIVING PATTERNS AND CHARACTERISTICS
• ALCOHOLISM
• ALCOHOLISM AND THE FAMILY
• ALCOHOLISM AND ME
• ALCOHOL AND THE HUMAN BODY
FOR SPECIFICS OF PAHSP COURSE SEE INSTRUCTORS GUIDE
NOTE: INSTRUCTOR OR CLIENT MAY REQUEST PSYCHO-MEDICAL TREATMENT FOR CLIENT DURING ANY PHASE OF COURSE. APPROPRIATE REFERRAL AND FOLLOW-UP SHOULD BE MADE
COURT DISPOSITION OF CASE PAHSP CERTIFIES COMPLETION OF COURSE

LESSON PLAN II

(Two Hour Course Instruction)

A. *SPECIFIC TOPIC:* Alcohol and the Human Body.

B. *GENERAL OBJECTIVE:* To understand alcohol abuse as a social problem and the extent to which alcohol abuse impairs the mind and body.

C. *SPECIFIC OBJECTIVES:*

(1) To understand the reason for contradictory attitudes toward alcohol by our society;

(2) To understand the physiological process of alcohol absorption, metabolism, and elimination;

(3) To know chemical tests for measurement of alcohol in the blood;

(4) To understand behavioral changes associated with an increase in alcohol consumption;

(5) To learn the effects of alcohol on judgment, muscular control and vision;

(6) To understand how the body reacts to high BAC's.

D. *COURSE CONTENT:* See attached lecture.

E. *METHODS AND MATERIALS:*

(1) *METHODS:* Lecture (60 minutes); ***Alcohol and the Human Body*** (14 minutes), ***or To Your Health*** (10 minutes), and ***Collision Course*** (17 minutes). Remainder of hour for discussion of film, review questions, and course content topics.

(2) *MATERIALS:*

(a) Projector for film
(b) ***Drinking Myths*** (Student Reading)
(c) ***Every 13th Drink*** (Student Reading)
(d) ***Drinking Clock*** (Classroom Demonstration)
(e) ***The Alcoholism Disease Exhibit*** (Classroom Demonstration)

F. ***DISCUSSION AND REVIEW QUESTIONS:***

(1) How nutritional a food is alcohol?

(2) When ingested, how does the body absorb alcohol?

(3) How does metabolism alter the effects of alcohol on the body?

(4) How is unused alcohol eliminated by the body?

(5) What is blood alcohol concentration (BAC) and what is its' significance?

(6) What are the adverse effects of increasing BAC's on vision, muscular coordination, and judgment?

(7) What are the behavioral characteristics of intoxicated persons?

(8) With BAC's 0.15% and better, what are some of the disabling effects a person experiences when they are "naive" (non-tolerant) drinkers?

(9) Approximately how many highway fatalities each year can be attributed to alcohol abuse? Why is the total so high?

LESSON PLAN II – COURSE CONTENT

ALCOHOL AND THE HUMAN BODY

Every year Americans drink over 275 million gallons of hard liquor, 1,600 million gallons of beer and ale, and 170 million gallons of wine. Studies have demonstrated that 68% of the adult population drink alcohol at least once a year; 77% of the men and 60% of the women. Surveys indicated that 12% of Americans are heavy drinkers, one-fifth of the adult men and one-twentieth of the adult women. The above American drinking practices, is further compounded by the fact that alcohol problems are hidden in a massive clustering of dysfunctional behavior such as crime, suicide, industrial problems, family instability, and ***automobile accidents.*** The scientific study of alcohol use and abuse as a social problem has enhanced our awareness of how complex the problem is and how difficult it has become to communicate and conceptualize what we think we know about alcohol abuse or alcoholism. We know in general that Americans have become dependent on alcohol as a social lubricant and as a means of tension reduction. We know that alcohol is used to relieve insecurity and anxiety.

We know from 1960 to 1970, per capita consumption of alcohol in the United States increased 26%. According to the National Institute on Alcohol Abuse and Alcoholism approximately 10 million Americans of the 95 million drinkers within the United States are now either full-fledged alcoholics or at least serious problem drinkers. Following heart disease and cancer, alcoholism is the country's biggest health problem, causing approximately 13,000 deaths per year directly related to cirrhosis of the liver. We know an alcoholic's life span is shortened by 10 to 12 years.

The National Council on Alcoholism indicates that over 6% of the United States workers are alcoholic in varying degrees, and that on the average, compared to non-alcoholics, an alcoholic costs his employer an ***extra*** equivalent sum of 25% of his salary. For all United States businesses, the loss is put at approximately 10 billion dollars in absenteesim, 2 billion in health and welfare services, and 3 billion in property damage, medical expenses, workmen's compensation claims, and insurance which adds up to a staggering "15 billion dollar hangover." Alcoholics tend to be typically between the ages of 35 to 50, 30% of them are blue collar workers, normally in the more skilled categories such as machinists or electricians, 45% are professional or managerial personnel. People who abuse alcohol are seven times more likely to be separated or divorced than the general population.

All of the above statistics regarding alcohol abuse or alcoholism lead us to the most critical of these and the main reason why all of you are in the Pennsylvania Alcohol-Highway Safety Program, and that is, the relationship of alcohol use and abuse to highway fatalities and automobile accidents. Fatalities and injuries as a result of automobiles has constituted what has been designated as the major public health problem of our times. There is an estimated total number of deaths exceeding 2 million, increasing annually by some 50,000 more dead and over 5 million injured. Among persons under 35 years of age, highway crashes are the major single cause of death. It is known that ethyl alcohol can impair perception and sensory, psychomotor, and mental functions.

Actual operation of motor vehicles on experimental field courses, as well as laboratory tests, show that blood alcohol levels as low as 0.03 to 0.04% are sufficient to cause deterioration of performance. This inverse relationship, an increase in blood alcohol level and a decrease in driving performance, gains strength until at 0.10% significant effects are noted in all drivers. The relationship between the number of drinks one imbibes and the concentration of alcohol in the blood is noted in ***ABC's of Drinking and Driving.***

INSTRUCTOR'S NOTE:

Stop discussion and give each student the ***ABC's of Drinking and Driving.*** Explain that most of what you will be talking about is in this brief booklet. All students should read the material for the next class.

In general, alcohol is metabolized in the body at a fairly constant rate. As a person drinks at a rate faster than the alcohol can be metabolized, the drug accumulates in his body resulting in higher and higher concentrations of alcohol in the blood. Specifically, it is the amount of alcohol actually concentrated in the body fluids not the amount consumed which determines intoxication; however, the effects of alcohol vary with an individual's personality, physical condition, the amount of food in his stomach, and the duration of his drinking. In addition, the constant user of alcohol may gradually build up a tolerance for the drug so that increasing amounts may be needed to produce dysfunctional effects. In general, alcohol is metabolized at approximately the rate of one drink per hour. A typical drink is: (1) a shot of spirits approximately 1.5 ounces of 40-50% pure alcohol, (2) a glass of wine approximately 7 ounces of 12% pure alcohol, or (3) a pint of beer approximately 16 ounces or 5% pure alcohol. At a rate of one drink per hour a given individual will demonstrate little if any accumulation of alcohol in the bloodstream.

INSTRUCTOR'S NOTE:

Stop discussion and present ***Alcohol and the Human Body*** (14 minutes) ***or To Your Health*** (10 minutes). Following the film, answer any questions pertaining to what has been presented in the film.

Summary of Alcohol Absorption and the Human Body

Alcohol is absorbed directly into the bloodstream and does not require any digestion. Approximately 20% of the alcohol is absorbed through the walls of the stomach, the remainder is absorbed through the small intestines. The chief deterrent to the absorption of alcohol is food. Eating while one drinks slows down the rate of absorption. Milk is popularly known as an effective food in slowing down the rate of absorption. After absorption, alcohol is distributed throughout the blood. Following absorption, the next process is metabolism or the oxidation of the alcohol. The liver is the principal organ where alcohol is metabolized. At the present time, there is no known method of

increasing the rate at which alcohol is oxidized. Neither hot coffee, cold showers or brisk walks speed up that process, and only time can "sober up" the intoxicated individual. Approximately 90% of all alcohol is metabolized in the liver. Alcohol is excreted, chemically unchanged, in the urine, breath, and perspiration. About 10% of the total amount of alcoholic beverage that is consumed, is excreted in this manner. A blood alcohol concentration of 0.10% means that the level of alcohol concentration is .10 grams or 100 milligrams of alcohol per 100 cubic centimeters of blood.

In Pennsylvania, blood alcohol levels at 0.10% define legal intoxication. At this level, muscular coordination, speech and vision are impaired and thought processes are confused. When the blood alcohol level reaches approximately 0.45 to 0.50%, the entire neural balance is upset and the individual "passes out." Usually, blood alcohol levels above 0.50% are lethal.

Chemical tests provide objective criteria of intoxication and permit invaluable studies of the role of alcohol in fatal accidents.

For the student's information, when they were arrested for DUI, the breath testing device that was used to determine legal intoxication was in compliance with the Federal standards as defined by the Commonwealth of Pennsylvania's Uniform Vehicle Code.

INSTRUCTOR'S NOTE:

During the discussion of Alcohol and the Body you may find it helpful to demonstrate BAC levels by using the Drinking Clock. ***Also,*** present the film ***Collision Course*** (17 minutes). It demonstrates clearly that an increase in blood alcohol levels is related to a deterioration in driving skill. Finally, before class ends, briefly discuss the two student readings ***Every 13th Drink*** and ***Drinking Myths.***

LESSON PLAN III
(Two Hour Course Instruction)

A. ***SPECIFIC TOPIC:*** Nature and Scope of Drinking and Driving Problem.

B. ***GENERAL OBJECTIVE:*** To understand the relationship of drinking, driving and traffic accidents.

C. ***SPECIFIC OBJECTIVES:***

(1) To know accident data related to problem drinkers;

(2) To know the distribution of fatal drivers by BAC;

(3) To understand the probability of an accident following the first DUI offense;

(4) To learn the relative probability of causing an accident by BAC.

D. ***COURSE CONTENT:*** See attached lecture.

E. ***METHODS AND MATERIALS:***

(1) ***METHODS:*** Lecture and small group discussion (90 minutes; film ***Drink, Drive, Rationalize*** (26 minutes).

(2) ***MATERIALS:***

(a) Projector for film
(b) ***Drinking Clock*** (Classroom Demonstration)
(c) ***The Alcoholism Disease Exhibit*** (Classroom Demonstration)
(d) ***The Way To Go*** (Student Reading)

F. ***DISCUSSION AND REVIEW QUESTIONS:***

(1) What is the extent of the accident problem in the nation involving drinking drivers?

(2) What relationship is there to BAC above 0.15% and accidents?

(3) To what extent is BAC related to fatal accidents?

LESSON PLAN III

NATURE AND SCOPE OF DRINKING DRIVING PROBLEM

Although there is a great deal known about the association between alcohol consumption and the impairment of driving behavior there still remains many areas of uncertainty. One of the major controversial issues is concerned with the classification of drinking drivers. One of the main difficulties in arriving at such an understanding is the absence of an agreed upon and generally accepted and behaviorally based definition of alcohol abuse or alcoholism. The literature is replete with such terms as "problem drinker," "alcoholic," "alcohol addict," "pre-alcoholic," and so forth. Such terms have been used in general within the Alcohol-Highway Safety field to describe those alcohol abusing persons involved in highway accidents.

Dr. Robert F. Borkenstein, Professor of Police Administration, Indiana University, has listed several descriptive categories of drinking drivers.

(1) Drinking drivers who drink compulsively and uncontrollably but are skilled in their driving habits. This type of drinking driver usually has blood alcohol concentrations above 0.15% and more often than not are consistently reported blood alcohol levels above 0.20%. Many recent studies within the Commonwealth of Pennsylvania demonstrate that the average blood alcohol level upon arrest is 0.19%.

(2) Drinking drivers whose personality is overly aggressive and as a result are not good drivers under most circumstances. In general, they are not compulsive drinkers although alcohol impairs their driving skills significantly enough that their basic aggressive personality contributes to a deterioration in driving skill.

(3) Drinking drivers to whom neither driving or drinking seems to be a major problem. They have on occasion had too much to drink and in turn have impaired their driving skill. Most DUI offenders seem to indicate that they believe that they are within this category, i.e., "social drinkers."

(4) Drinking drivers who because of possibly some physiological involvement with alcohol are very sensitive to alcohol effects.

(5) Drinking drivers who are beginners or learners in both their driving and drinking habits. In general, this class includes the youthful drinker and driver. His or her experiences in each area is limited and therefore somewhat uncertain and unpredictable.

(6) Drinking drivers who because of age or illness have over the years impaired their driving skill. Alcohol use only accentuates the slow deterioration of the driving skill.

(7) The drinking driver who basically has no problem with driving or drinking but consistently manages to maintain a low impairment level while driving his automobile. This type of driver rarely is involved in DUI Countermeasures Programs.

There is a significant amount of evidence to indicate that the drinking driver primarily associated with category No. 1 is involved in a disproportionate amount of fatal crashes.

The DUI population has been shown to be heterogeneous and in all probability consists of a number of subgroups, most of which can be classified as "problem drinkers." There is, of course,

the possibility that a so-called "social drinker"might be arrested for DUI on the basis of an occasional or even isolated incidence of alcohol abuse. Most research throughout the country and within the Commonwealth of Pennsylvania would agree that a significant proportion of DUI offenders are classified and/or diagnosed as "problem drinkers." Depending on the particular group of DUI offenders studied and the definitions of alcoholism that are used, this proportion of "problem drinkers" within the Commonwealth of Pennsylvania and throughout the country can range from between 50-70% of the studied arrested population. In general, many would argue that anyone arrested for DUI has a potential drinking problem. The Philadelphia Alcohol-Highway Safety Program's diagnosis and evaluation system used to formulate and to assign people into the various components of the program have over the years delineated various individual's drinking patterns, personality profiles, and general lifestyles. Pennsylvania's experience and research indicates that blood alcohol levels of more than 0.10% (legal intoxication in the Commonwealth of Pennsylvania) is regarded by the Criterion Committee of the National Council on Alcoholism as being clearly and definitively associated with the ***development*** of alcoholism. On this basis, it would certainly seem reasonable to suppose or suspect that any person who has been arrested with a blood alcohol concentration of 0.15% or more could be automatically regarded as a serious problem drinker or alcoholic person. Add to one's BAC, previous arrests for DUI or other alcohol-related offenses within the preceding five years and you have a high indicator of suspected alcoholism.

INSTRUCTOR'S NOTE:

Stop your discussion and entertain questions. Some students will attempt to challenge your remarks. Listen carefully and summarize their "rationalizations." Following your brief discussion (10-15 minutes) present the film ***Drink, Drive, Rationalize*** (26 minutes). Entertain approximately 10 minutes of discussion.

Blood Alcohol Levels and Automobile Accidents and Fatalities

In the United States, over 50,000 people are killed on our highways each year. Half of the fatal accidents involve the use of alcohol. Twenty-five to forty percent of all injuries involved in automobile accidents is associated with the use of alcohol. Approximately 0.2% of the Gross National Product or 2 billion dollars per year is the estimated economic cost for alcohol-related crashes.

Although the question of the effect of alcohol on gross behavioral changes is not yet fully resolved, the results are unanimous in showing that driving skills already begin to deteriorate at blood alcohol levels below 0.05%. This level of alcohol in the blood would be reached broadly speaking in a person weighing 190 lbs. who had consumed three (3) 12 ounce beers or three (3) drinks containing one (1) ounce each of 86 proof alcohol one hour before driving. Although other factors such as presence of food in the gastrointestinal track influence the rate of entrance of alcohol into

the bloodstream a 120-pound person would achieve a blood alcohol level of 0.05% with less than two (2) beers or less than two (2) drinks containing an ounce of whiskey each. Investigations concerning the role of levels of alcohol in the blood in motor vehicle accidents has been conducted since the early 1930's. In 1950, Bjerver and Goldberg found that increasing concentrations of alcohol in the blood were related to a number of driving errors, e.g., carelessness, reduced exactitude in steering and braking, more frequent stalling at critical moments, etc. Graff in 1962 added to this list the fact that 0.05% alcohol in the blood produced a tendency to drive toward road ditches in 82% of the cases. With 0.10% blood alcohol levels, drivers consistently fluctuated between low and high speeds, swerved from lane to lane, and used excessive amounts of time to return to the correct lane. West using experimental driving tests concluded that blood alcohol levels of 0.10% adversely affect normal driving performance by 15% with deterioration increasing to 30% with blood alcohol levels at 0.15%.

Smith and Popham in their experimental controlled study indicated that drivers with 0.15% blood alcohol levels and over were involved 25 times more often in an accident than their controlled group. Extrapolating from their findings, it is estimated that accident involvement with blood alcohol levels between 0.05% and 0.10% is two to seven times greater than persons at zero BAC and at 0.15%, it is approximately 25 times greater. These estimates are given indirect support by studies which show a positive correlation between blood alcohol levels and other serious relevant variables such as extent of damage, expense of damage, and severity of injury. ***There is no question that the probability of vehicle accidents increases sharply as the driver's blood alcohol level increases.***

Coroners' reports on levels of blood alcohol found by autopsies reveal high concentrations of blood alcohol in fatal accident victims. McCarrol and Hadden in their site-matched controlled study found that 46% of the accident responsible group had blood alcohol concentrations of 0.25% and over. In contrast, not a single one of the drivers in the control group had a concentration in that range. Hadden and Bradess, replicating the above study, noted that 50% of fatally injured drivers had blood alcohol levels of 0.15% or more at the time of death.

The Michigan Highway Safety Research Institute case histories investigations of Wayne County, Michigan indicate that, of the drivers in single car crashes, 58% exceeded 0.15% BAC's, and 43% of the drivers in multiple car crashes also exceeded 0.15% BAC. Another significant finding of the Michigan Research Group is that drivers involved in fatal vehicle accidents in general had inferior driving records when compared with the normal population.

INSTRUCTOR'S NOTE:

Stop your discussion, if you have summary data regarding your class, present the findings. If not, ask each student to state his BAC at time of arrest and show how the national data is "in your class" and in turn local community.

The Department of Transportation's Alcohol Countermeasures Program of June, 1970, analyzed the relationship between BAC and fatalities. In Chart 3-1, data is presented for three groups. The first bar on the graph represents drivers randomly stopped on roads at the scene and time of fatal accidents and given breath tests: 2% of these drivers had BAC's over 0.10%. In other words, one in fifty drivers on the road at these times and places is a DUI offender. The second bar represents the BAC measurement of drivers fatally injured who are judged ***not*** to be at fault: 12% had BAC's of 0.10% or over. The third bar represents the BAC's of drivers fatally injured who ***are*** judged at fault: 53% had BAC's of 0.10% or over. Thus, while only 2% of the drivers on the road are DUI, they account for half of the drivers "at fault" in fatal accidents.

INSTRUCTOR'S NOTE:

Attempt to show how your class data relates to the "at fault" group.

Philadelphia Alcohol-Highway Safety Program research indicates that blood alcohol levels above 0.15% are significantly associated with alcohol consumption rates consistently noted in serious problem drinkers. There is also a significant association between BAC and alcohol-related behaviors such as early morning drinking, "blackouts," or memory lapses related to drinking episodes, and a variety of other alcohol-related disorders.

Finally, an Indiana University Study, under the direction of Dr. Robert Borkenstein, attempted to estimate the probability that a driver will be involved in at least one accident with a DUI driver during his lifetime. There is a 50-50 chance that any driver will be in some kind of accident involving a DUI offender during his driving lifetime (defined as 50 years of driving). There is about one chance in ten that an innocent driver will be involved in a fatal accident with a DUI offender during that innocent driver's driving lifetime.

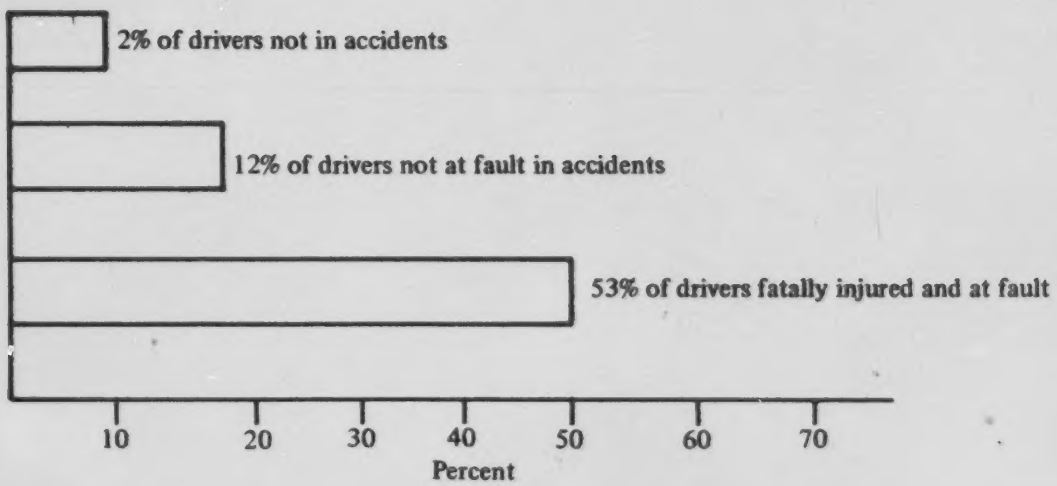
The findings of these and several other studies confirm that increasing levels of blood alcohol are associated with an increasing incidence of automobile crashes and even more directly related to serious or fatal crashes when greater than 0.10%.

INSTRUCTOR'S NOTE:

Please make sure that each student has a copy of ***The Way To Go*** for his homework assignment.

CHART 3-1

BLOOD ALCOHOL ABOVE 0.10% AND FATAL ACCIDENTS



SOURCE: "Alcohol Safety Countermeasures Programs," National Highway Traffic Safety Administration, Department of Transportation, June 8, 1970, pp. 2-9.

LESSON PLAN IV
(Two Hour Course Instruction)

A. ***SPECIFIC TOPIC:*** Drinking and Driving Patterns and Characteristics.

B. ***GENERAL OBJECTIVE:*** To understand the drinking driver incidence and impaired driver characteristics and patterns.

C. ***SPECIFIC OBJECTIVES:***

(1) To understand the characteristics of driving patterns of impaired drivers;

(2) To know the probability of automobile drivers who have been drinking;

(3) To know the polydrug use of DUI offenders;

(4) To know the psychological characteristics of drinking drivers;

(5) To know the abnormal driving behaviors associated with intoxication;

(6) To understand the youthful drinking driver;

(7) To know when you have had too much and what to do.

D. ***COURSE CONTENT:*** See attached lecture.

E. ***METHODS AND MATERIALS:***

(1) ***METHODS:*** Lecture (90 minutes); small group discussion (30 minutes).

(2) ***MATERIALS:***

(a) NIAAA ***Signs of Alcoholism*** (Student Reading)
(b) State of Vermont – "Methods to Control Drinking Pattern" (Student Reading)

F. ***DISCUSSION AND REVIEW QUESTIONS:***

(1) What percent of drivers on roads at all hours have recorded BAC of 0.05%?

(2) What percent of drivers on roads at all hours have recorded BAC of 0.10%?

(3) What age groups have the highest exposure during nighttime driving? Who represents the greatest number of drinking drivers?

(4) How many violations per year would be committed by 100 DUI drivers?

(5) When do you know you have had too much to drink?

(6) How can you slow down your drinking?

LESSON PLAN IV

DRINKING AND DRIVING PATTERNS AND CHARACTERISTICS

INSTRUCTOR'S NOTE:

In considering the drinking and driving patterns of arrested DUI offenders, it is important to pay particular attention to the way in which most DUI offenders are apprehended. A few examples of deviations from normal driving will indicate to the student why the police officer was alerted and why he made the initial stop.

Ask every student to indicate how many of the following behaviors they remember from their arrest for DUI.

Most DUI offenders are apprehended because they demonstrated some of the following poor driving behaviors: (1) unreasonable speed where geographical characteristics or other circumstances would ordinarily compel a more moderate rate of travel, (2) weaving from the road edge to the white line with sharp, jerky movements in the correcting direction of travel, (3) driving in spurts, first slow and then fast or vice versa, (4) frequent lane changes coupled with excessive speed, (5) improper passing without sufficient clearance or cutting in, taking too long, or swerving too much in overtaking and passing another vehicle, (6) over-shooting or disregarding traffic signs or signals, (7) approaching signs or signals unreasonable fast or slow and stopping or attempting to stop with uneven motions, (8) driving at night without lights, delay in turning them on after starting from a parked position, (9) driving at night with parking lights, (10) failure to dim lights when approaching traffic repeatedly indicates to the suspect that his lights are on bright, (11) unnecessary use of turn indicators, (12) driving in low gears without apparent reasonable cause or repeatedly meshing or clashing gears, (13) jerky starting or stopping, (14) driving unreasonably slow, (15) driving too close to curbs or appearing to hug the shoulder or center of the roadway or continually straddling the center lanes of other lane markings, (16) driving with windows rolled down in cold weather, (17) driving or riding with head partly or completely out the window.

INSTRUCTOR'S NOTE:

Based on the above, you should now entertain small group discussions for 15 or 20 minutes to validate many of these issues and also to incorporate some ideas that have not generally been known about the reasons why police apprehended a given DUI offender.

Nighttime driving for each age group is noted in Chart 4-1. The graph demonstrates clearly the relationship of fatalities with blood alcohol concentrations of 0.05% or higher. Particular note should be given to the idea that persons under 25 years of age are both drinking and driving more than the normal distribution of age categories and in turn more will be involved in accidents and killings that are alcohol-related. Note that all three distributions peak at age 21 to 25. This clearly suggests that drinking driving should emphasize the younger age group below 25.

Fine, ***et. al.*** indicate through their research study in Philadelphia County, that the highest percentage of drinking, (80% of the problem drinking categories) are between the ages of 20 and 24 years. There is a general tendency for drinking to decrease with advancing age. A sharp decrease in problem drinking is noted after 40 years of age. Apparently the youthful drinker (under 25 years) is a serious problem not only within the general alcoholism field but also in alcohol-highway safety.

In the Grand Rapids, Michigan Study, 70% of the drinking was noted in the evening hours. Thirty-seven percent of those evening drinkers indicated that they thought they could drive safely after more than five drinks.

Based on National and Commonwealth of Pennsylvania statistics, the latter generated primarily from Philadelphia and Berks Counties, one should note that more than 50% of first offender DUIs were married, 21% were single. Between 60% and 80% of those arrested were fully employed at the time of their DUI arrest and almost two-thirds of the first offenders were below the age of 45.

Chart 4-2 indicates the times of drinking offenses to locations and to the time of night. Please note that drinking offenses after midnight, at all locations and for all traffic conditions, show a sharp increase. The time of night also has a relationship to BAC's, with a slow increase in the percentage of drinking drivers until midnight and then a rapid upswing from midnight to 1:00 a.m. The rapid increase of drinking drivers is combined with a dramatic decrease in traffic volume. Chart 4-3 indicates the number and percent of persons with positive BAC's at specific time periods.

Polydrug Use and DUI Offenders

Philadelphia-based research indicates that approximately 20% of first time DUI offenders admit to using both drugs and alcohol: 4.5% Barbiturates; 9% Tranquilizers; 2.3% Amphetamines; and 8.9% Marijuana/Hashish.

When one compares polydrug users with those only using alcohol, it should be noted that there is more serious alcohol abuse patterns in polydrug users. The above data suggest that some serious DUI offenders seem to have histories of polydrug abuse which needs to be taken into consideration when planning for treatment programs.

INSTRUCTOR'S NOTE:

Try to engage the student in a discussion of polydrug use.

Psychological Factors in Drinking Drivers

Numerous studies have established that problem drinkers or alcoholics have higher rates of alcohol-related accidents than social drinkers. Considerable controversy still exists concerning the responsible factors, with some authorities arguing that physiological impairment caused by excessive alcohol intake is the most important factor, while others feel that personality characteristics such as impulsiveness, hostility, and suicidal tendencies, exacerbated by alcohol, are most significant. It is likely that a complex interaction of these variables, in a particular individual, results in a person at high risk of becoming involved in an automobile accident. Personality factors in alcoholics are presumed more important than sensorimotor impairment, while in younger, non-alcoholic drivers with the same blood alcohol levels, impairment of sensorimotor function is primarily responsible. A full understanding of the problem of the drinking driver requires intensive study of the demographic, social, and psychological characteristics of persons involved. The personality traits observed in intoxicated persons involved in accidents include chronic hostility, depression, feelings of omnipotence, invulnerability, self-destructiveness, egocentricity, and decreased tolerance to tension.

Alcohol intoxication might thus be responsible for automobile accidents not only because it impairs sensorimotor functions, but also because of its potential for reducing emotional control, and releasing self-destructive impulses. Certain combinations of personality difficulty are highly predictive of accident potential in alcoholics. It appears that interplay between deleterious personality traits which are liberated by alcohol, and the impairment of skill caused by intoxication, is responsible for an excess of traffic accidents in which death may occur. Selzer and Ehrlich have also suggested that factors other than simply intoxication might affect accident rates of alcoholics, and place special emphasis on social or psychological stress.

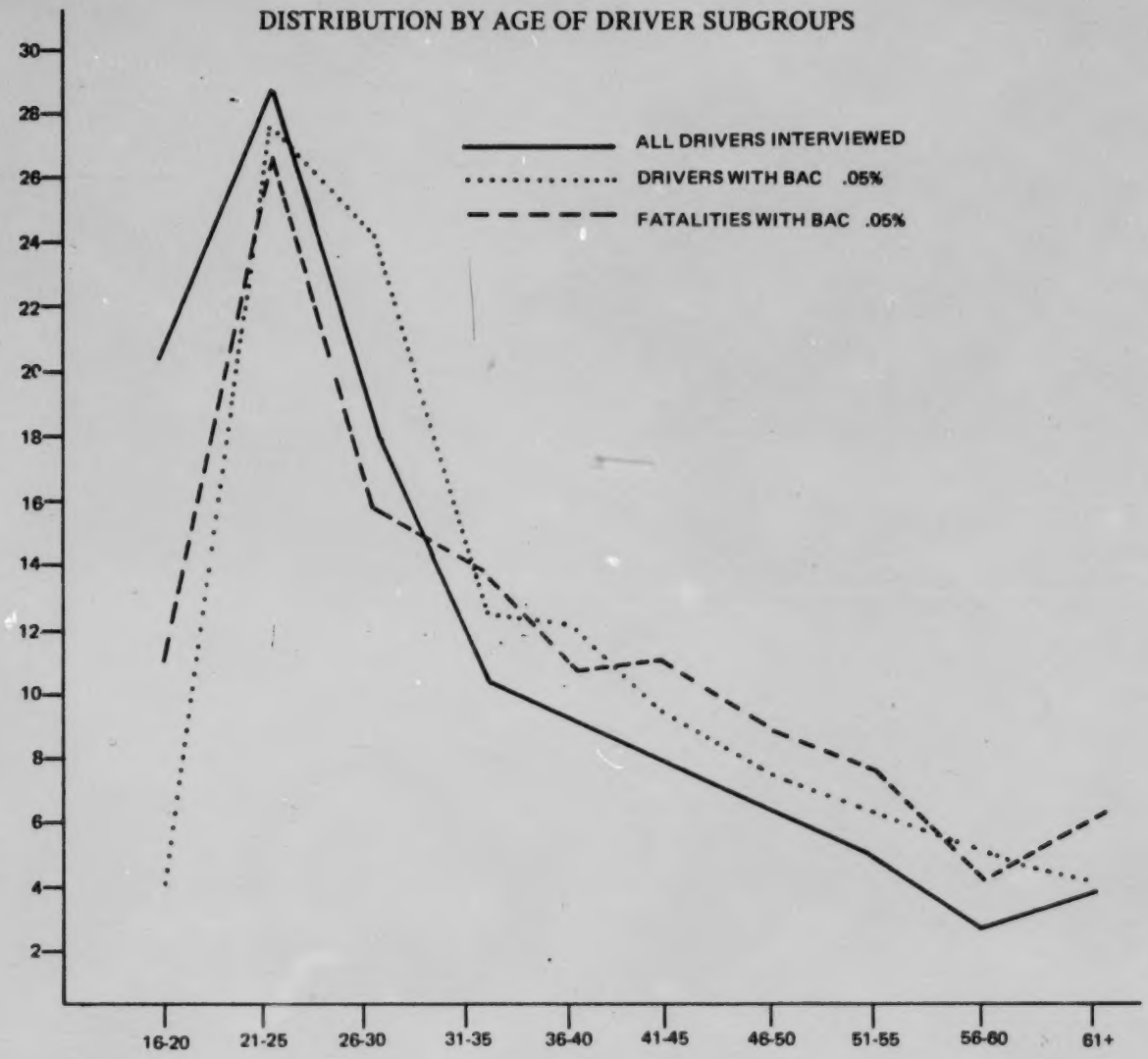
In summary, it can be stated that tests of overall drinking ability become meaningless if only psychomotor concepts are considered. Equally important are the effects of alcohol in reducing inhibitions, altering self perception and self confidence, changing attitudes and value judgments.

INSTRUCTOR'S NOTE:

At this point in the discussion, the instructor should refer everyone to ***Controlling Drinking Patterns*** handout. Try to emphasize the need to look at the DUI offender's problem in a more responsible manner. Review with the student the 20 points indicated in the State of Vermont Project Crash Summary. Remember, our intention is to, at a minimum, have the offender consciously make an effort to be more responsible about his drinking and driving. If we can at least convince the DUI offender to be more responsible about his drinking we can assume that he will drive at lower and lower blood alcohol levels.

Chart 4-1

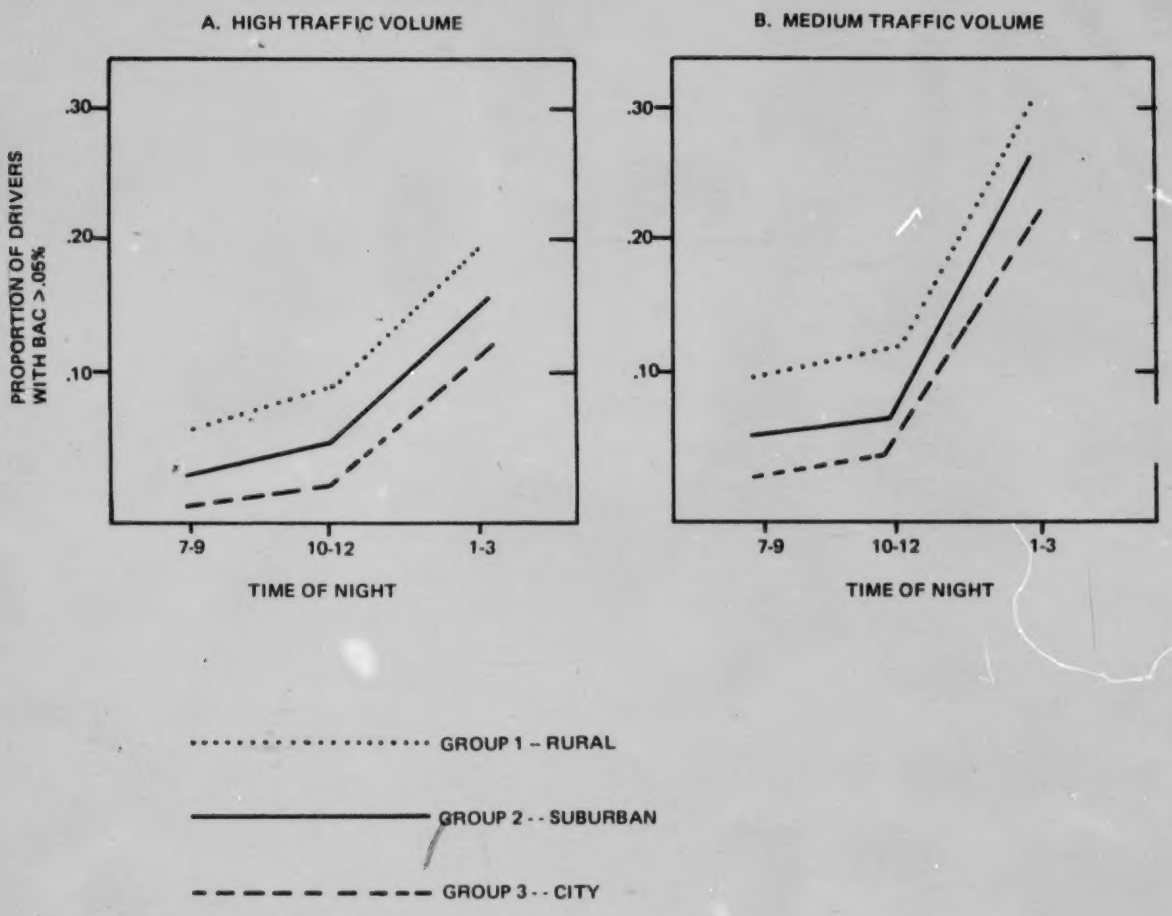
DISTRIBUTION BY AGE OF DRIVER SUBGROUPS



SOURCE: CARLSON,W.L., AND OTHERS. "WASHTENAW COUNTY BAC ROADSIDE SURVEY," ANN ARBOR, MICHIGAN: HIGHWAY SAFETY RESEARCH INSTITUTE, UNIVERSITY OF MICHIGAN, SEPTEMBER, 1971, p. 28.

Chart 4-2

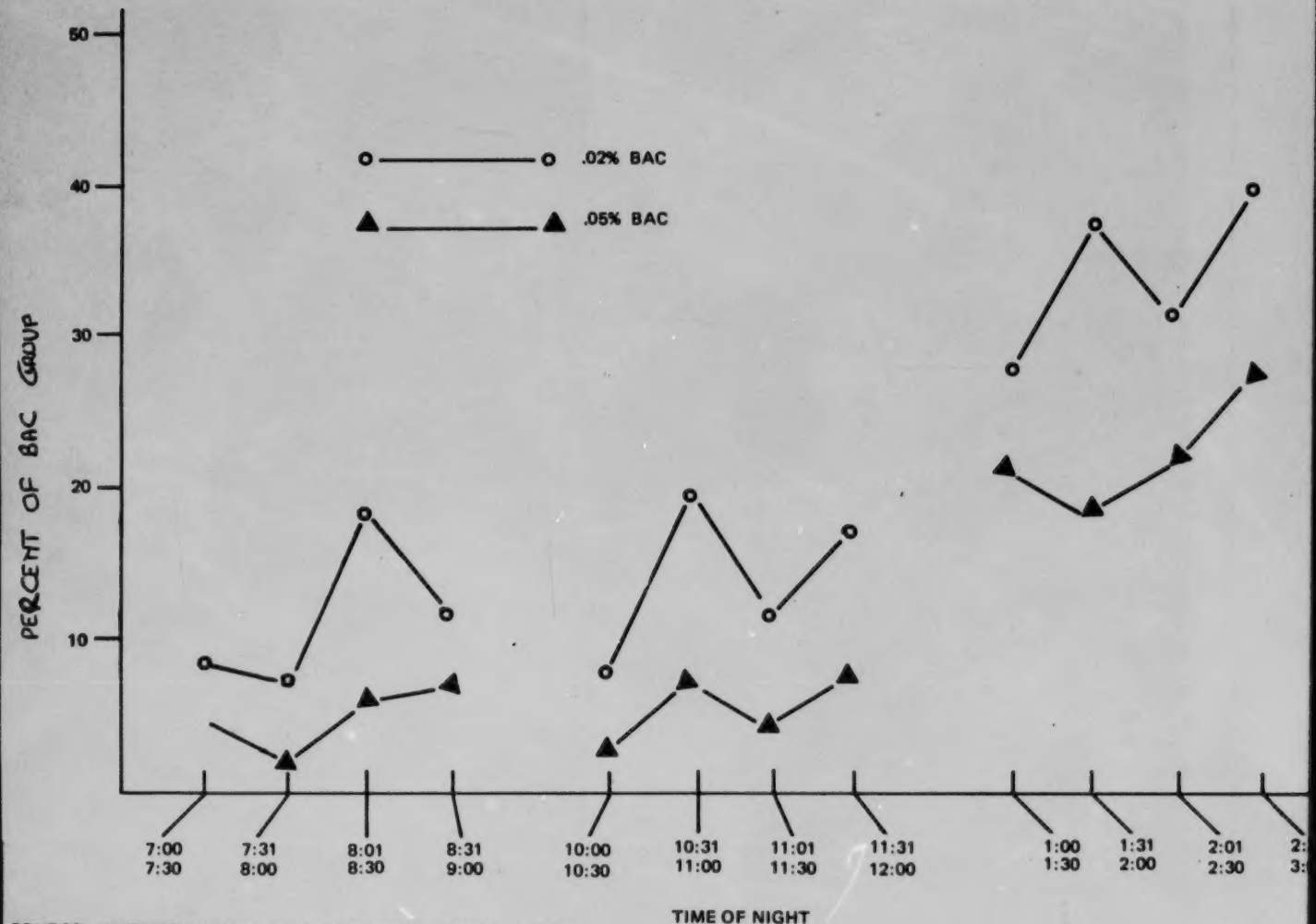
LOCATION OF DRIVERS HAVING HIGH BACs



SOURCE: CARLSON, W.L., AND OTHERS. "WASHTENAW COUNTY BAC ROADSIDE SURVEY," ANN ARBOR, MICHIGAN: HIGHWAY SAFETY RESEARCH INSTITUTE, UNIVERSITY OF MICHIGAN, SEPTEMBER, 1971, P. 25.

Chart 4-3

PERCENTAGE OF DRINKING DRIVERS BY TIME OF NIGHT



SOURCE: WASHTENAW COUNTY BAC ROADSIDE SURVEY, P. 23.

LESSON PLAN V
(Two Hour Course Instruction)

A. ***SPECIFIC TOPIC:*** The Problem Drinker/Alcoholism.

B. ***GENERAL OBJECTIVE:*** To understand the phases of alcohol addiction and the American alcoholic.

C. ***SPECIFIC OBJECTIVES:***

(1) To learn the extent of alcoholism in the United States;

(2) To know the concept of alcohol addiction;

(3) To understand the myths about problem drinkers.

D. ***COURSE CONTENT:*** See attached lecture.

E. ***METHODS AND MATERIALS:***

(1) ***METHODS:*** Lecture (70 minutes) on course content; ***The Alcoholic Within Us*** (25 minutes); and small group discussion (25 minutes).

(2) ***MATERIALS:***

(a) Overhead projector
(b) ***Four Steps to Recovery*** (Student Reading)
(c) "Drinking Diary" (Student Reading)

F. ***DISCUSSION AND REVIEW QUESTIONS:***

(1) Can a drinking driver be an alcoholic and be unaware of his/her problem? If so, why?

(2) Can you see alcoholism as a progressive disease? If so, how?

(3) What is the extent of alcoholism in the United States?

(4) Can you identify at least three myths about problem drinkers?

LESSON PLAN V

THE PROBLEM DRINKER/ALCOHOLISM

Alcohol-Dysfunctional Behavior

Ingestion of alcoholic beverages in the United States carries with it social psychological functions and meanings. It is important to recognize that alcohol use and abuse is also related statistically and behaviorally to many public health concerns.

Alcohol and Crime

Federal Bureau of Investigation statistics indicate that over 31% of all arrests per year are made for public drunkenness. If arrest charges related to drunkenness such as drinking driving, disorderly conduct, and vagrancy were added to the figures, alcohol would play a part in nearly half of all arrests. In institutional adjusted felons incarcerated for at least six months in Lewisburg Penitentiary in Pennsylvania, over 21% of that population had been arrested on alcohol-related charges, primarily involving auto theft or cashing worthless checks. New York City police records indicate that alcohol is often involved in homicide, assault, offenses against children and major theft.

The connection between alcohol abuse and crime is of obvious importance to the well being of any community. The President's Commission on Law Enforcement and Administration and Justice recommended that alcohol abuse be handled not as a crime but as a public health problem since alcohol abuse imposes a heavy burden on the criminal justice system.

Alcohol and Mental Health

The complexity of alcohol use and abuse within the field of mental health practice is interwoven with many aspects of mental health. Serious dilemmas can arise when attempts are made to separate out, from the massive clustering of human pathology, those aspects of behavior which are primarily alcohol-related and those which are not.

Statistical evidence demonstrates that there is a consistent correlation between alcohol abuse and suicide. Many studies indicate that approximately one-third of all suicide victims are also chronic alcoholics. The United States Health, Education and Welfare Study of 134 consecutive suicides in a large metropolitan area demonstrated that alcoholics and depressed people account for more than 75% of this suicidal group. The scope of the problem is greater when one looks at admissions and discharges from psychiatric facilities. Findings reveal that close to one in four newly admitted patients to State mental hospitals are diagnosed as alcoholic at the time of admission. In most community general hospitals, a close scrutiny of the major medical problems would indicate that approximately one in ten individuals admitted were suffering from alcohol abuse, irrespective of their primary diagnosis at hospital admission. A further study of the "hidden alcoholic" in

the community general hospital indicated that this figure is closer to one in four. It is a well known fact that alcoholics or serious problem drinkers adversely affect the mental health of two or three family members, predisposing approximately 30 million individuals to the destructive impact of this disorder. Jellinek indicates that the death rate at birth for children in alcoholic families is nearly twice as high as in temperant families.

Epidemiological and sociological studies show the following factors indicate high risk for the development of alcoholism.

(1) A family history of alcoholism including parents, siblings, grandparents, uncles, and aunts.

(2) A history of teetotalism in the family, particularly where strong moral overtones are present and most particularly where the social environment of the patient has changed to associations in which drinking is encouraged or required.

(3) A history of alcoholism or teetotalism in the spouse or the family of the spouse.

(4) Coming from a broken home or home with parent discord, particularly where the father was absent or rejected.

(5) Being the last child of a large family.

(6) Although some cultural groups, for example, the Irish and Scandinavians, have a higher incidence of alcoholism than others, such as Jews, Chinese, and Italians; individuals should be aware that alcoholism can occur in people from any culture derivation.

(7) Having female relatives of more than one generation that had a high incidence of recurrent depressions.

(8) Heavy drinking is often associated with heavy smoking, but the reverse need not be true.

INSTRUCTOR'S NOTE:

Discuss with the class these high risk indicators. ***Remember***, they are indicators not facts about alcoholism.

Following your discussion, give each student the ***Four Steps to Recovery*** and explain the process of alcohol addiction.

Four major warning signs of approaching alcoholism or alcohol abuse are:

(1) ***Increased Consumption*** – One of the first serious signs of problems associated with alcohol use is when the individual gradually increases his consumption from month to month. Often the individual will begin to worry about his drinking at this point.

(2) ***Extreme Behavior*** – Under the influence of alcohol, many individuals will commit various acts which leaves them feeling guilty and embarrassed the next day. Their alcohol indulgence in many ways is getting out of control.

(3) ***Blackouts*** – After an evening of drinking, the individual cannot remember what happened during a significant amount of time.

(4) ***Morning Drinking*** – Many serious drinkers reduce their hangovers by giving themselves a "bracer" to help them start the day.

The above early warning signs can be significantly enhanced due to support from the spouse regarding excessive drinking.

INSTRUCTOR'S NOTE:

Allow yourself at least sixty (60) minutes to present and discuss ***The Alcoholic Within Us***. The film will stress many of the issues raised during your lecture on alcohol addiction. It might be to your advantage to spend fifteen (15) minutes discussing your lecture prior to the film. It might facilitate the student being more introspective and self-disclosive regarding his/her alcohol patterns.

LESSON PLAN VI
(Two Hour Course Instruction)

A. ***SPECIFIC TOPIC:*** Alcoholism and Family Disruption.

B. ***GENERAL OBJECTIVE:*** To understand the early warning signs of alcohol abuse on family dysfunction.

C. ***SPECIFIC OBJECTIVES:***

(1) To know the attempts one makes to deny alcohol abuse as a part of the family problem;

(2) To understand the attempts that a family makes to eliminate the alcohol problem;

(3) To know the disorganization and disruption caused by alcohol abusers within the family;

(4) To understand the efforts to escape from the problem;

(5) To appreciate the recovery and recognition of the whole family.

D. ***COURSE CONTENT:*** See attached lecture.

E. ***METHODS AND MATERIALS:***

(1) ***METHODS:*** Lecture (40 minutes); Films: ***The Summer We Moved to Elm Street*** (27 minutes) and ***All Bottled Up*** (11 minutes); small group discussions with significant other (spouse) (45 minutes).

(2) ***MATERIALS:*** None

LESSON PLAN VI

ALCOHOLISM AND FAMILY DISRUPTION

INSTRUCTOR'S NOTE:

The next two sessions should involve a significant other, in particular the spouse. This lecture should be organized around a very brief discussion of family drinking patterns in known DUI programs and some general information about the adjustment of families to the crisis of alcoholism.

Fine, ***et.al.*** in their extensive study of over 1,500 first offenders arrested for DUI in Philadelphia County indicate that drinking practices in families play an important role in influencing DUI offender's drinking habits. A significant association was found between the degree of alcohol impairment reported by the DUI offender and the seriousness of drinking reported in the individual's family of origin. Generally, the heavier the past family drinking pattern, the more likely the DUI offender would be a problem drinker. Utilizing a similar statistical procedure for the offender's present family structure, they were able to establish a significant association between problem drinking impairment levels and current family drinking patterns. If the spouse or significant other person living with the offender drank heavily, the offender was also more likely to be a problem drinker. Only 19% of the social drinkers reported heavy drinking patterns in their families, while, in the problem drinking category, 65% of the problem drinkers reported heavy drinking patterns in their current family.

Alcoholism and Children

People working in the field of alcoholism are painfully aware that the climate found in most alcohol abusing homes is extremely unsatisfactory. Although there may be relatively harmonious periods, the organization of the alcoholic family unit is usually found to be disrupted, with confusion of roles, constant stresses and tensions in various stages of eruption, and a multitude of problems directly and indirectly related to the alcohol abuse. There is little doubt that this climate is the resultant of a complex of factors. The alcohol dependency itself is often generated and perpetuated by intrafamilial conflict. Personality traits such as low frustration tolerance, irresponsibility, impulsiveness, egocentricity and need to escape from reality are frequently seen in alcoholics, making them very inadequate family members. Wives of alcoholics undoubtedly have an unenviable task in coping with a disturbed husband, but not infrequently they too have personality problems which in turn contribute to the husbands' alcoholism, and the family chaos. When this is added to the unpredictable and dysfunctional behavior produced by the action of a disinhibiting drug such as

alcohol, and the response by the family members to this behavior, a vicious circle is established which makes the alcohol abusing family a veritable arena of potential disaster of the worst kind.

Fine, ***et. al.***, in a study of the influence of parental alcoholism, demonstrated very clearly that for children aged eight to twelve years, those with parental alcoholism were significantly more disturbed than normal children. Compared with normal children, those in a family with parental alcoholism are less able to maintain attention, less responsive to environmental stimulation and much more prone to emotional upset. They tend to be anxious, fearful individuals who have great difficulty in containing or regulating their excitement or mood. They are subject to aggressive behavior, and show evidence of deficient learning of certain moral codes of conduct. They are also socially isolated, and preoccupied with inner thoughts rather than a concern for what is going on around them.

Further indication of the detrimental effects of parental alcoholism can be found in the greater frequency of symptoms such as stuttering, unreasonable fears, bed-wetting after age six, isolation and temper tantrums in children of alcoholics. There is little doubt that in the majority of cases these symptoms are related to the effect of parental alcoholism on the functioning of the family unit.

There are probably no better examples of parentally rejected children than those youngsters in many alcoholic homes. This is often associated with a pervasive sense of shame which children feel for a parent who is frequently intoxicated. The phenomenon of rejection itself has received attention by researchers, who have shown that rejected children are emotionally unstable, restless, overactive, given to troublemaking, resentful of authority, more inclined to steal and quarrelsome. These characteristics are frequently seen in children from alcoholic backgrounds where, inevitably, the rejection is accompanied by other undesirable forms of parental behavior.

> ***INSTRUCTOR'S NOTE:***
>
> The instructor should allow 10 minutes for discussion and then present film: ***All Bottled Up*** (11 minutes). This film depicts parental drinking patterns and their effect on youth. Following a 10-15 minute discussion, you should lecture on alcoholism and family disruption.

Alcoholism and Family Disruption

The behavior of family members in each phase of an alcohol crisis contributes to the form to which the crisis takes. In general, most problem drinkers at the time of their initial marriage are able to convince the spouse that their drinking habits are within socially acceptable limits. In a few cases, people who are already alcoholics manage to hide this from their fiance. Many people who knew about the spouse's drinking pattern prior to marriage, like relatives and friends, think that marriage will "straighten out" the problem. Most women have no conception of what their husbands alcohol

abuse problems are or were at the time of their marriage. During the First Stage of the family's adjustment, the husband tends to drink excessively and sporatically and in turn, places strain on the husband/wife interaction. During Stage Two, the spouse begins to drink excessively, he starts to isolate himself from important family events and interactions, his behavior and attitudes and thoughts become very alcohol-drinking oriented. In general, the wife begins to feel self pity and lose her confidence in her husband and in turn, tension and anxiety arises when they begin to interact.

The original family structure becomes disrupted, and as mentioned earlier, if children are exposed to this kind of disruption, they begin to show some emotional disturbances. During the Third Stage of family adjustment, the family gives up attempts to control the drinking and begins to behave in a manner which relieves immediate tension or anxiety with no concern for long-term objectives. Children become much more disturbed and anxious and nervous. There is no longer an attempt on the part of the wife to maintain the husband's image as a bread-winner and father to the children. The wife at times may begin to question her own sanity regarding her inability to effectively deal with the problem. During the Fourth Stage, the wife takes over control of the family and in many ways the husband becomes another child. The wife feels sorrow and pity for her husband and no longer seems to experience resentment or hostility. The family tends to organize itself around minimizing the husband's disruption during his alcoholic episodes. If one does not seek effective counseling at this point, Stage Five will develop where the wife, out of her own necessity to live a productive life, will separate from her husband if she can resolve the problems and conflicts surrounding this action. During the Sixth Stage, the wife and children reorganize as a family without the husband and finally, during Stage Seven, the husband if he realizes the seriousness of the family disruption may achieve sobriety and family harmony, attempting to reorganize himself as a sober father. The above stages characterize some of the typical courses alcoholism takes in relation to family patterns. The above pattern does not fit every family problem regarding alcoholism just like every alcoholic does not fit the typical pattern known as alcoholism, but it does provide us with a general outline of some of the ways in which many problem drinkers have moved through social drinking and eventually into alcoholism and in turn, have provided a tremendous amount of disruption within the family lifestyle.

INSTRUCTOR'S NOTE:

At this point, the instructor should reflect on the above ideas and begin a group discussion regarding what are the attempts that have been made within the DUI offender's family to alieviate the problem of drinking and in particular, drinking and driving.

About 50 minutes before class ends you should show the film ***The Summer We Moved to Elm Street*** (27 minutes) followed by a group discussion.

LESSON PLAN VII
(Two Hour Course Instruction)

A. *SPECIFIC TOPIC:* Alcoholism and Me.

B. *GENERAL OBJECTIVE:* To understand the effects of alcohol use and abuse on one's lifestyle.

C. *SPECIFIC OBJECTIVES:*

(1) To feel the personal disruption alcohol has had on the individual's lifestyle;

(2) To sensitize one to his/her personal experiences with alcohol abuse;

(3) To self-disclose your action plan regarding his/her personal "bout" with alcohol.

D. *COURSE CONTENT:* See attached lecture.

E. *METHODS AND MATERIALS:*

(1) *METHODS:* Film: ***Conspiracy of Silence*** (28 minutes); small group discussions with significant other (90 minutes).

(2) *MATERIALS:*

(a) Projector for film
(b) ***AA A Brief Guide to Alcoholics Anonymous*** (Student Reading)
(c) ***Facilities Guide*** for treatment resources in your community (Student Reading)

LESSON PLAN VII

ALCOHOLISM AND ME

INSTRUCTOR'S NOTE:

The instructor should attempt to involve the spouse or significant other in this Lesson Plan. The film ***Conspiracy of Silence*** should be shown followed by a group discussion. The discussion should accent the need for help or counseling regarding alcohol use and abuse. All individuals who are problem drinkers should disclose what their action plan is regarding their alcohol abuse patterns. The instructor should pay specific attention to the ***Facilities Guide*** for treatment resources in their particular county and in turn, discuss on the blackboard some of the kinds of resources available and what each treatment resource specializes in within the community. For example, outpatient services specifically geared toward family problems, or in-patient care for detoxification of alcohol addiction, etc.

Lesson Plan VI and VII fit logically together. If you did not have enough time to complete Lesson Plan VI, it can be easily integrated into Lesson Plan VII.

LESSON PLAN VIII
(Two Hour Course Instruction)

A. *SPECIFIC TOPIC:* Review of DUI Educational Safe Driving Program.

B. *GENERAL OBJECTIVE:* To understand what impact the DUI Educational Safe Driving Program had on one's future drinking and driving behavior.

C. *SPECIFIC OBJECTIVES:*

(1) To assess student's progress in meeting course objectives;

(2) To assess instructor's progress in meeting course objectives;

(3) To assess student and teacher feedback about the course.

D. *COURSE CONTENT:* All that the student and instructor can reflect on regarding the prior seven lesson plans.

E. *METHODS AND MATERIALS:*

(1) *METHODS:* Small group discussions (60 minutes); Post-course Data Collection (45 minutes); Certificate Ceremony (15 minutes).

(2) *MATERIALS:*

(a) Post-Course Data Material (KI and O.S. and Blank 8½" x 11" Paper)
(b) Treatment Facilities Guide
(c) Certificates of Completion

F. *DISCUSSION AND REVIEW QUESTIONS:*

(1) In what areas have I made significant progress?

(2) In what areas have I had difficulty?

(3) In what areas have I not learned?

(4) In what areas could I have learned more?

(5) How could the teacher have facilitated my learning more?

LESSON PLAN VIII

REVIEW OF DUI EDUCATIONAL SAFE DRIVING PROGRAM

INSTRUCTOR'S NOTE:

For approximately one hour you should discuss with each DUI student what he has accomplished in the educational course. For example, what areas has he made some progress in? What areas has he had some difficulty? What areas has he not learned? What areas has he learned something significant? And again, how could you as a teacher be a better facilitator to an individual's learning experience? Following this discussion, you should administer all post-course data collection material, that is, the KI and OS forms.

Following the data collection, a brief 15 to 20 minute ceremony should conclude the course on DUI instruction. It is important that each student feel a sense of graduation from the DUI Safe Driving School Program.

APPENDIX A

COURSE EVALUATION

DUI EDUCATIONAL SAFE DRIVING SCHOOL

COMMONWEALTH OF PENNSYLVANIA

ALCOHOL-HIGHWAY SAFETY PROGRAM

PRE-COURSE DATA COLLECTION

(This material was developed, tested, and retested by Dr. James L. Malfetti, Teachers College of Columbia University in cooperation with the New York State Department of Motor Vehicles and the New York State Automobile Association.)

STUDENT NO.

CONFIDENTIAL

DUI EDUCATIONAL SAFE DRIVING SCHOOL
PENNSYLVANIA ALCOHOL-HIGHWAY SAFETY PROGRAM

The information asked for in this collection is confidential and is ***NOT*** for Court records. In no way will it be used against you.

There are a number of different types of questionnaires in this collection for which there are individual instructions. It is your responsibility to read each set of directions carefully and to answer all questions completely ON THE ANSWER SHEET.

Because your answer sheet will be machine-scored, it is essential that you follow the general instructions on how to properly mark the answer sheets that are provided in the questionnaire packet. You are to use the No. 2 pencil distributed to you. PLEASE READ EACH OF THE INSTRUCTIONS CAREFULLY.

If you have a question, just raise your hand and someone will help you.

When you finish, please bring the collection packet to the instructor.

You may turn the page and begin.

DO NOT SEPARATE OR WRITE IN THIS QUESTIONNAIRE PACKET

GENERAL INSTRUCTIONS

How To Mark The Answer Sheet

In this test you will be instructed to select the best choice of the suggested alternative answers for each question and record your choice with a medium No. 2 pencil on a separate answer sheet.

In all cases, you must show your answer to a question by darkening completely the box corresponding to the letter that is the same as the letter of your answer. You MUST keep your mark within the box. If you should have to erase a mark, be sure to erase it completely.

Mark only one answer for each question.

Be sure to mark all answers on the answer sheet; answers in the test booklet do not count.

12 HOURS PRIOR TO ARREST FORM

Directions:

Think of the 12 hours before your DUI arrest. Read the following questions and ***ON THE ANSWER SHEET blacken in*** the appropriate letter to show how you feel:

1. What would you call the 12 hours before your DUI arrest?
   A. An unusual day D. A usual day

2. During what hours did you start drinking?
   A. Morning: 8 a.m. to noon B. Afternoon: 12 noon to 4 p.m.
   C. Evening: 4 p.m. to 8 p.m. D. Late evening: 8 p.m. to 12 midnight
   E. Early morning: 12 midnight to 8 a.m.

3. Where did you drink?
   A. Bar B. Home C. Friend's home
   D. Office E. Automobile

4. With whom did you drink?
   A. Husband or wife B. Other relatives
   C. Friends D. Strangers E. Alone

5. What did you drink?
   A. Beer B. Wine
   C. Whiskey, vodka or gin D. Cocktails E. Other

6. Approximately how much did you drink during this time?
   A. 0 - 2 drinks B. 3 - 4 drinks
   C. 5 - 6 drinks D. 7 - 10 drinks
   E. 11 drinks or more

7. Why did the police stop you?
   A. Traffic violation B. Automobile defect C. Accident

8. When were you arrested?
   A. Morning: 8 a.m. to noon B. Afternoon: 12 noon to 4 p.m.
   C. Evening: 4 p.m. to 8 p.m. D. Late evening: 8 p.m. to 12 midnight
   E. Early morning: 12 midnight to 8 a.m.

9. What was the occasion for drinking?
   A. Celebration B. After work C. Tragedy
   D. Business E. None

10. Why did you drink?
   A. Lonely B. Angry C. Escape
   D. Upset E. No reason

11. How much are you to blame for the events that led to your arrest?
   A. Not at all to blame B. Slightly to blame
   C. Somewhat to blame D. Mostly to blame
   E. Entirely to blame

12. Do you feel it was fair to be arrested?
   A. Not at all fair B. Slightly fair C. Somewhat fair
   D. Mostly fair E. Entirely fair

13. What do you believe are your chances of being arrested again on a DUI charge within the next year?
   A. No chance B. Very little chance
   C. 50-50 chance D. 75% chance E. 100% chance

14. How difficult will it be to change your behavior that led to your arrest?
   A. Very easy B. Somewhat easy C. Somewhat difficult
   D. Difficult E. Extremely difficult

15. How valuable do you feel this course will be for you?
    A. Not at all valuable B. Slightly valuable
    C. Fairly valuable D. Valuable
    E. Extremely valuable

16. What will you do to avoid a future DUI arrest?
    A. Will seek help with drinking problem
    B. Will use alternate transportation when drinking
    C. Will drink less when planning to drive
    D. Will drink at home

KNOWLEDGE ATTITUDE INVENTORY

Directions:

This inventory contains 20 multiple choice questions. Each question has five choices. Choose the one best answer in each case and ***ON THE ANSWER SHEET blacken in*** the appropriate letter. Your score will be the number right. Answer every question.

17. Which will "sober you up" if you want to drive?
    A. black coffee B. a cold shower C. time
    D. vigorous exercise E. all of the above

18. What temporary visual condition can occur from drinking alcohol?
    A. reduced side vision B. blurring C. seeing double
    D. all of the above E. none of the above

19. A person suffering from alcoholism is:
    A. always drunk B. unable to control how much he drinks
    C. usually unemployed D. often a "skid row" bum
    E. all of the above

20. Alcohol is a factor in approximately what percentage of fatal automobile crashes?
    A. 10% B. 20% C. 30% D. 40% E. 50%

21. Which of the following describes the action of alcohol on the body?
    A. depressant B. stimulant C. both stimulant and depressant
    D. neither a stimulant nor a depressant E. none of the above

22. Problem drinkers account for what proportion of driving after drinking accidents?
A. 5% B. 20% C. 50% D. 70% E. 90%

23. Which part of the driving task is made worse by five or more drinks?
A. seeing the situation B. deciding what to do E. taking action
D. B and C E. A, B and C

24. As you drink more alcohol, your ability to drive:
A. steadily improves
B. improves at first, but then gets worse
C. may get better or worse, depending on certain factors
D. worsens at first but then gets better
E. steadily worsens

25. If a 155 pound man drives after drinking ten ounces of whiskey within one hour, his chances of having an accident are:
A. 1/2 normal B. normal C. twice normal
D. five times normal E. over 15 times normal

26. Which of the following statements is true?
A. A shockingly large number of people drive after drinking excessively.
B. Most fatal accidents involving alcohol show very high levels of alcohol.
C. The involvement of alcohol in accidents tends to be overestimated in most statistics.
D. A and B
E. A, B and C

27. The number of persons killed in the United States last year in traffic accidents was approximately:
A. 55,000 B. one-half the total number of America's war deaths
C. 15,000 D. 500,000 E. 5,000

28. Three to five ounces of whiskey on an empty stomach will make the average person:
A. think he can do things that he cannot actually do
B. believe he is performing better than he really is
C. less sure of himself
D. A and B
E. A, B, and C

29. For each one ounce drink of whiskey, a person should wait before driving:
A. 15 minutes B. 30 minutes C. 1 hour D. 2 hours E. 3 hours

30. Compared to crashes not involving alcohol, those involving alcohol tend to be:
    A. more severe for all drivers
    B. more severe for younger drivers only
    C. of about the same severity for all drivers
    D. more severe for older drivers only
    E. less severe for all drivers

31. The effects of alcohol are most dangerous for:
    A. unexpected emergencies
    B. driving backwards
    C. speeding
    D. driving at night
    E. driving on a crowded road

32. Which of the following is true?
    A. Beer, wine, rum, whiskey and gin all contain alcohol.
    B. A quart of wine contains more alcohol than a quart of beer.
    C. A quart of beer contains more alcohol than a pint of whiskey.
    D. A and B
    E. A, B and C

33. If 100 men and women each drank ten ounces of whiskey in one hour, reaction time would probably:
    A. speed up in most men, but slow down in most women
    B. stay the same in most persons
    C. speed up in about 20, but slow down in about 80
    D. speed up in all 100 persons
    E. slow down in all 100 persons

34. How does the body get rid of most alcohol? It is:
    A. removed through urination
    B. "burned up" in the liver
    C. exhaled with the breath
    D. digested in the intestines
    E. removed through perspiration

35. Which of the following influences the effects of alcohol?
    A. the amount of food in the stomach
    B. the body weight of the individual
    C. the height of the individual
    D. A and B
    E. A, B and C

36. Which is ***not*** a realistic and effective way of avoiding driving while intoxicated:
    A. making arrangements to have someone who will not be drinking drive you if you know you will be drinking
    B. eating heartily before you begin drinking
    C. limiting your drinks to one per hour if you will be driving
    D. planning to use another form of transportation (e.g., bus, taxi, etc.) if you know you will be drinking
    E. not driving to where you will drink knowing you will have to find some other way to get home

DRIVING OPINION SURVEY

Directions:

Here are a list of statements relating to drinking and driving. We are interested in seeing how you feel about different aspects of this subject. Therefore, please read each statement carefully, and tell if you agree or disagree with it by ***blackening*** the appropriate letter, A or B, ***ON THE ANSWER SHEET.***

Many people feel differently about each of the statements so there is no "right" or "wrong" answer for any particular one.

For Example:

		Agree A	*Disagree* B
1.	Driving is more enjoyable after a drink.	—	—
2.	The law should go easy on first time DUI offenders.	—	—

If you agree with statement 1 above, you would ***blacken in*** the first column ***ON THE ANSWER SHEET*** headed "A". If you disagree, you would ***blacken in*** the column "B".

Looking at statement 2, if you thought that the law should go easy on first time DUI offenders, you would ***blacken in*** the "A" column. If you disagree, you would ***blacken in*** the "B" column.

Respond to all of the statements in this fashion, according to whether ***you*** agree or disagree with them. ***Remember there are no "right" or "wrong" answers.*** We just want to know how ***you*** feel. Be sure to respond to every statement. Choose only one answer for each statement.

37. If you have just one or two drinks you can drive just as well as without them.

38. The experienced driver is rarely bothered by a few drinks.

39. I would not feel safe riding with a driver who had consumed eight drinks.

40. There is little harm in a drink before driving.

41. The law should limit the amount of alcohol that is served to a person who drives to a bar.

42. I would feel safe riding with a driver who had recovered from alcoholism.

43. Doctors should be required to report drivers who are alcoholic to the Department of Motor Vehicles.

44. Often the relaxing effect of a drink can improve driving.

45. No one should drink and then drive.

46. Most books on the relation between alcohol and driving exaggerate the effects of alcohol.

47. Some persons can drink and then drive safely.

48. Some people can handle emergencies better while driving after a few drinks.

49. It's okay to drive after a few drinks but it's not okay to drive after many drinks.

50. A person convicted of driving while intoxicated should have his license revoked.

51. Tests to determine the alcoholic content of the body should be required of suspected drinking drivers.

52. After four drinks, some people drive worse, but some people can drive just as well as without them.

53. Not enough arrests are currently made for driving while intoxicated.

54. Arrest for driving under the influence of alcohol should carry a stiff fine.

55. Most people are more cautious behind the wheel after drinking.

56. Hosts and hostesses should limit the amount of alcoholic beverages served to driving guests.

DUI EDUCATIONAL SAFE DRIVING SCHOOL

COMMONWEALTH OF PENNSYLVANIA

ALCOHOL-HIGHWAY SAFETY PROGRAM

POST-COURSE DATA COLLECTION

(This material was developed, tested, and retested by Dr. James L. Malfetti, Teachers College of Columbia University in cooperation with the New York State Department of Motor Vehicles and the New York State Automobile Association.)

STUDENT NO.

CONFIDENTIAL

DUI EDUCATIONAL SAFE DRIVING SCHOOL
PENNSYLVANIA ALCOHOL-HIGHWAY SAFETY PROGRAM

The information asked for in this collection is confidential and is ***NOT*** for Court records. In no way will it be used against you.

There are a number of different types of questionnaires in this collection for which there are individual instructions. It is your responsibility to read each set of directions carefully and to answer all questions completely ON THE ANSWER SHEET.

Because your answer sheet will be machine-scored, it is essential that you follow the general instructions on how to properly mark the answer sheets that are provided in the questionnaire packet. You are to use the No. 2 pencil distributed to you PLEASE READ EACH OF THE INSTRUCTIONS CAREFULLY.

If you have a question, just raise your hand and someone will help you.

When you finish, please bring the collection packet to the instructor.

You may turn the page and begin.

DO NOT SEPARATE OR WRITE IN THIS QUESTIONNAIRE PACKET

GERNERAL INSTRUCTIONS

How To Mark The Answer Sheet

In this test you will be instructed to select the best choice of the suggested alternative answers for each question and record your choice with a medium No. 2 pencil on a separate answer sheet.

In all cases, you must show your answer to a question by darkening completely the box corresponding to the letter that is the same as the letter of your answer. You MUST keep your mark within the box. If you should have to erase a mark, be sure to erase it completely.

Mark only one answer for each question.

Be sure to mark all answers on the answer sheet; answers in the test booklet do not count.

12 HOURS PRIOR TO ARREST FORM

Directions:

Think of the 12 hours before your DUI arrest. Read the following questions and ***ON THE ANSWER SHEET blacken in*** the appropriate letter to show how you feel:

1. How much are you to blame for the events that led to your arrest?
   A. Not at all to blame B. Slightly to blame
   C. Somewhat to blame D. Mostly to blame
   E. Entirely to blame

2. Do you feel it was fair to be arrested?
   A. Not at all fair B. Slightly fair C. Somewhat fair
   D. Mostly fair E. Entirely fair

3. What do you believe are your chances of being arrested again on a DUI charge within the next year?
   A. No chance B. Very little chance C. 50-50 chance
   D. 75% chance E. 100% chance

4. How difficult will it be to change your behavior that led to your arrest?
   A. Very easy B. Somewhat easy C. Somewhat difficult
   D. Difficult E. Extremely difficult

5. How valuable do you feel this course has been for you?
   A. Not at all valuable B. Slightly valuable
   C. Fairly Valuable D. Valuable E. Extremely valuable

6. In the year before this DUI arrest, about how many times were you driving after drinking as much as you had at the time of this arrest?
   A. None B. 1 - 2 C. 3 - 7 D. 8 - 25 E. Over 25

7. What will you do to avoid a future DUI arrest?
   A. Will seek help with drinking problem
   B. Will use alternate transportation when drinking
   C. Will drink less when planning to drive
   D. Will drink at home

ON THE SEPARATE BLANK SHEET WRITE THE FULL DETAILS OF WHAT YOU WILL DO TO AVOID A FUTURE DUI ARREST.

AFTER COMPLETING YOUR STATEMENT CONTINUE WITH QUESTION 8 WHICH FOLLOWS.

KNOWLEDGE ATTITUDE INVENTORY

Directions:

This inventory contains 20 multiple choice questions. Each question has five choices. Choose the one best answer in each case and ***ON THE ANSWER SHEET blacken in*** the appropriate letter. Your score will be the number right. Answer every question.

8. Which will "sober you up" if you want to drive?
   A. Black coffee B. A cold shower C. Time
   D. Vigorous exercise E. All of the above

9. What temporary visual condition can occur from drinking alcohol?
   A. Reduced side vision B. Blurring C. Seeing double
   D. All of the above E. None of the above

10. A person suffering from alcoholism is:
   A. Always drunk B. Unable to control how much he drinks
   C. Usually unemployed D. Often a "skid row" bum
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11. Alcohol is a factor in approximately what percentage of fatal automobile crashes:
    A. 10% B. 20% C. 30% D. 40% E. 50%

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    D. B and C E. A, B and C

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    A. Steadily improves
    B. Improves at first, but then gets worse
    C. May get better or worse, depending on certain factors
    D. Worsens at first, but then gets better
    E. Steadily worsens

16. If a 155 pound man drives after drinking ten ounces of whiskey within one hour, his chances of having an accident are:
    A. 1/2 normal B. Normal C. Twice normal
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17. Which of the following statements is true?
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    C. The involvement of alcohol in accidents tends to be overestimated in most statistics.
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    C. Exhaled with the breath D. Digested in the intestines
    E. Removed through perspiration

26. Which of the following influences the effects of alcohol?
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    D. Planning to use another form of transportation (e.g., bus, taxi, etc.) if you know you will be drinking
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Many people feel differently about each of the statements, so there is no "right" or "wrong" answer for any particular one.

For Example:

		Agree A	***Disagree*** B
1.	Driving is more enjoyable after a drink.	—	—
2.	The law should go easy on first time DUI offenders.	—	—

If you agree with statement 1 above, you would blacken in the first column ***ON THE ANSWER SHEET*** headed "A". If you disagree, you would blacken in column "B".

Looking at statement 2, if you thought that the law should go easy on first time DUI offenders, you would blacken the "A" column. If you disagree, you would blacken in the "B" column.

Respond to all of the statements in this fashion, according to whether ***you*** agree or disagree with them. ***Remember there are no "right" or "wrong" answers.*** We just want to know how ***you*** feel. Be sure to respond to every statement. Choose only one answer for each statement.

28. If you have just one or two drinks you can drive just as well as without them.

29. The experienced driver is rarely bothered by a few drinks.

30. I would not feel safe riding with a driver who had consumed eight drinks.

31. There is little harm in a drink before driving.

32. The law should limit the amount of alcohol that is served to a person who drives to a bar.

33. I would feel safe riding with a driver who had recovered from alcoholism.

34. Doctors should be required to report drivers who are alcoholic to the Department of Motor Vehicles.

35. Often the relaxing effect of a drink can improve driving.

36. No one should drink and then drive.

37. Most books on the relation between alcohol and driving exaggerate the effects of alcohol.

38. Some persons can drink and then drive safely.

39. Some people can handle emergencies better while driving after a few drinks.

40. It's okay to drive after a few drinks but it's not okay to drive after many drinks.

41. A person convicted of driving while intoxicated should have his license revoked.

42. Tests to determine the alcoholic content of the body should be required of suspected drinking drivers.

43. After four drinks, some people drive worse, but some people can drive just as well as without them.

44. Not enough arrests are currently made for driving while intoxicated.

45. Arrest for driving under the influence of alcohol should carry a stiff fine.

46. Most people are more cautious behind the wheel after drinking.

47. Hosts and hostesses should limit the amount of alcoholic beverages served to driving guests.

PLEASE BRING THIS COLLECTION BOOKLET TO THE INSTRUCTOR WITH YOUR ANSWER SHEETS.

APPENDIX B

Treatment Resources in Pennsylvania

Alcoholism Treatment Facilities Directory, published by Alcohol and Drug Problems Association of North America, 1130 Seventeenth Street N. W., Washington, D.C. 20036. 1-10 copies $7.50 plus 50¢ mailing per copy. While published in 1973, it is the most comprehensive listing of almost all state and local programs available.

Facilities Directories within a specific geographic area should be available at the Office of the Drug and Alcohol Authority for your county which would be listed in the Yellow Pages under Social Services.

Additionally, the Local Council of the National Council on Alcoholism also maintains a resource file on local Alcoholism Treatment Facilities in the Council's area and are listed in the telephone White Pages under National Council on Alcoholism.

If the above resources prove inadequate, the Governor's Council on Drug and Alcohol Abuse maintains an information clearinghouse known as ENCORE (717) 787-9761 located at the Riverside Office Building-One, 2101 North Front Street, Harrisburg, Pennsylvania 17110 for special information.

Additionally, there are four Division Offices located in four regions of Pennsylvania with staff available for special information and consultation needs. These offices are:

Division Office I

Mr. Jacob Armstrong, Chief
Alcohol Institute
915 Corinthian Avenue
Philadelphia, Pa. 19130
(215) 232-5550

Division Office II

Ms. Camille Fidrych, Chief
43 Main Street
Pittston, Pa. 18640
(717) 655-6801

Division Office III

Ms. Ellen Shoemaker, Chief
Riverside Office Center No. 2
2101 North Front Street
Harrisburg, Pa. 17120
(717) 783-8307

Division Office IV

Ms. Toni Williams, Chief
3406 Fifth Avenue, 3rd Floor
Pittsburgh, Pa. 15213
(412) 565-5765

APPENDIX C

Audio/Visual Resource Material:

Even without elaborate facilities a local DUI Educational Safe Driving School may be able to develop its own learning center for the collection of paperback books, reference books, tapes, slides, films, filmstrips, and other resources available to the student. Rental of films and tapes will have to be scheduled on a restricted time basis. One hopes that an Educational Resource Library will be developed by The Governor's Council on Drug and Alcohol Abuse and the Pennsylvania Department of Transportation so that centralized audio/visual resources can be maintained and updated yearly. Currently, the DUI Educational Safe Driving School will be utilizing the following resource material:

* Indicates inclusion in recommended course content. All others may be substituted but were judged to be lesser in quality due to length, material, content, or graphics.

Films:

A Snort History – may be purchased from:

Colorado Department of Health
Denver Alcohol Safety Action Project
1845 Sherman Street
Denver, Colorado
($55.00)

Alcohol and the Human Body – may be purchased from:

Sid Davis Productions
1046 South Robertson Boulevard
Los Angeles, California 90035
($170.00)

Alcohol: Our Number One Drug – may be purchased from:

Michael Harding
The Macmillan Company of Canada
70 Bond Street
Toronto, Ontario M5B 1X3
($150.00)

Alcohol and Red Flares – may be purchased from:

Sid Davis Productions
1046 South Robertson Boulevard
Los Angeles, California 90035
($260.00)

All Bottled Up – may be purchased or rented from:

International Tele-Film Enterprises
47 Densley Avenue
Toronto, Ontario M6M 5A8
($197.00) purchase price
($20.00 for 3 days rental)

Chalk Talk on Alcoholism – may be purchased or rented from:
(Parts I and II)

Father Joseph Martin
103 Fox Ridge Drive
Havre de Grace, Maryland 21078
($500.00) purchase price
(No Charge for rental)

Collision Course – may be purchased from:

Marketing Department
Addiction Research Foundation
33 Russell Street
Toronto, Ontario M5S2S1
($325.00) purchase price
($35 preview fee-deductable from purchase price if within 30 days)

Conspiracy of Silence – may be purchased from:

State of Nebraska
Division on Alcoholism
P.O. Box 94728
Lincoln, Nebraska 68509
($250.00)

David: Profile of a Problem Drinder – may be rented from:

National Film Board of Canada
1 Lombard Street
Toronto, Ontario

Drink, Drive, Rationalize – may be purchased or rented from:

Ontario Motor League – Toronto Club
2 Carlton Street
Toronto, Ontario M5B 1K4
($65.00) purchase price
(No Charge for rental)

Drivin' and Drinkin' – may be rented from:

Modern Talking Picture Service Inc.
1875 Leslie Street
Toronto, Ontario
(No Charge for rental)

Five Drinking Drivers – may be purchased or rented from:

Project Crash
P.O. Box 535
Waterbury, Vermont 05676
($150.00) purchase price
(No Charge for rental)

Go Sober and Safe – may be purchased from:

Highway Safety Foundation
Motion Picture Division
890 Hollywood Lane
P.O. Box 3563
Mansfield, Ohio 44907
($195.00)

or rented from:
National Highway Traffic Safety Administration
U.S. Department of Transportation
Washington, D.C. 20590
Contact: Ms. Clara Hardee
Technical Reference Branch

High Way To Die – may be purchased from:

Ms. Gail Thompson
CTV Television Network
42 Charles Street East
Toronto, Ontario M4Y 1T4
($225.00)

Party Scene – may be purchased or rented from:

Marketing Department
Addiction Research Foundation
33 Russell Street
Toronto, Ontario M5S 2S1
($40.00) purchase price
($30.00/week rental price)

Point Zero Eight – may be purchased from:

Film House Limited
22 Front Street West
Toronto 1, Ontario
($64.00)

may be rented from:

National Highway Traffic Safety Administration
U.S. Department of Transportation
Washington, D.C. 20590
Contact: Ms. Clara Hardee
Technical Reference Branch

So Long Pal – may be purchased from:

Norm Southerby & Associates
P.O. Box 15403
Long Beach, California 90815
($285.00)

or rented from:

National Highway Traffic Safety Administration
U.S. Department of Transportation
Washington, D.C. 20590
Contact: Ms. Clara Hardee
Technical Reference Branch

**The Alcoholic Within Us* – may be purchased or rented from:

Pyramid Films
2801 Colorado Avenue
Santa Monica, California 90404
($345.00) purchase price
($25.00 rental fee)

The First Step – may be purchased from:

Motivision, Ltd.
21 West 46th Street
New York, New York 10036
($395.00)

**The Summer We Moved to Elm Street* – may be purchased from:

National Film Board of Canada
1 Lombard Street
Toronto, Ontario
($260.00)

**To Your Health* – may be purchased from:

International Telefilm Enterprises
221 Victoria Street
Toronto 2, Ontario
Canada
($138.00)

Forms:

1) *12 Hours Prior to Arrest Forms* – as illustrated in "Rehabilitation Of The Drunken Driver," by E.I. Stewart and J.L. Malfetti.

2) *Knowledge Attitude Inventory* – as illustrated in "Rehabilitation Of The Drunken Driver," by E.I. Stewart and J.L. Malfetti.

3) *Driving Opinion Survey* – as illustrated in "Rehabilitation Of The Drunken Driver," by E.I. Stewart and J.L. Malfetti.

4) *Drinking Diary* – as illustrated in the New York State Drinking Driver Program, prepared by the State of New York Department of Motor Vehicles.

Brochures and Pamphlets:

1) *ABC's of Drinking and Driving* – published by:

National Council on Alcoholism
2 Park Avenue
New York, New York 10016

2) *Pennsylvania Manual for Drivers* – published by:

Department of Transportation
Commonwealth of Pennsylvania
Harrisburg, Pa. 17123

3) *Drinking Myths* – published by:

Operation Threshold
United States Jaycees
Box 7
Tulsa, Oklahoma 74102

4) *Every 13th Drink* – published by:

Hurley Hospital
Flint, Michigan

(William L. Keaton
Chief Alcoholism Therapist)

5) AAA *If You Drive . . . What About Drinking?* – published by:

Automobile Association
Traffic Safety Service
(Your local AAA Club)

(Transparencies: 1,2,3,4,5,6,7,8,9,10,11,12,13,15)

6) *The Way To Go* – published by:

Public Relations, D-1
Kemper Insurance Companies
Long Grove, Illinois 60049

7) NCA *What are the Signs of Alcoholism?* – published by:

National Council on Alcoholism
2 Park Avenue
New York, New York 10016

8) State of Vermont – "Methods to Control Drinking Patterns" – as illustrated in the New York State Drinking Driver Program, prepared by the State of New York Department of Motor Vehicles.

9) *Four Steps to Recovery* – published by:

Ayerst Laboratories
New York, New York 10017

10) AA – *A Brief Guide to Alcoholics Anonymous* – published by:

Alcoholics Anonymous World Services Inc.
Box 459
Grand Central Station
New York, New York 10017

11) *Facilities Guide* – (for treatment resources in your community)

Aids:

1) "Drinking Clock" – available from:

Spenco Medical Corporation
P.O. Box 8113
Waco, Texas 76710
(Health Educational Products Catalog – HE-1022 – $42.50)

2) "The Alcoholism Disease Exhibit" – available from:

Spenco Medical Corporation
P.O. Box 8113
Waco, Texas 76710
(Health Educational Products Catalog – HE-1054 – $65.50)

APPENDIX D

Alcohol-Highway Safety Selected Reading List:

A National Study of Adolescent Drinking Behavior, Attitudes and Correlates. Prepared by Research Triangle Institute for the National Institute on Alcohol Abuse and Alcoholism. National Technical Information Service, April 1975. (PB 246-002)

A Study of Prevalence and Intensity of Drug and Alcohol Use in the Commonwealth of Pennsylvania. Project Director, Elliot L. Rubin, Ph.D. Harrisburg: The Governor's Council on Drug and Alcohol Abuse. August 10, 1973.

A Survey of Court Procedures for Handling Problem Drinkers Convicted of Driving While Intoxicated. Available from National Technical Information Service, Springfield, Virginia 22151. Order (FH-11-7580 – Six Volumes).

Alcohol and Alcoholism: Problems, Programs, and Progress. NIMH, NIAAA, DHEW Publication No. (HSM) 72-9127, Revised 1972. Available from the National Clearinghouse for Alcohol Literature and Information (NCALI), P.O. Box 1156, Rockville, Maryland 20850. Phone: (301) 948-4450.

Alcohol and Alcohol Safety: A Curriculum Manual for Senior High Level – Volume I. Prepared by Abt Associates, Inc. Washington, D.C.: National Highway Traffic Safety Administration, 1972. (DOT HS 800705).

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APPENDIX E

Pennsylvania Alcohol-Highway Safety Program Judicial, Law Enforcement, County Officials, and Counseling and Rehabilitation Reference List:

All of the Manuals for the Pennsylvania Alcohol-Highway Safety Program can be obtained from the Pennsylvania Department of Transportation – Highway Safety Group:

Pennsylvania Alcohol-Highway Safety Program – Judicial Manual: Philadelphia: Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

Pennsylvania Alcohol-Highway Safety Program – Law Enforcement Manual: Philadelphia: Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

Pennsylvania Alcohol-Highway Safety Program – County Officials Manual: Philadelphia: Leiss Lithographers Press, 1976;

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PENNSYLVANIA ALCOHOL HIGHWAY SAFETY PROGRAM

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PREFACE

This Judicial Manual has been written by International Alcohol and Mental Health Associates, Inc. under the aegis of the City of Philadelphia's Coordinating Office on Drug and Alcohol Abuse Programs, Project Manager, Nicholas Piccone, Ed.D., Contract #6-3113 entitled "Curriculum and Instructors Guide for Use With Persons Arrested for Driving While Intoxicated (DWI)."

This Manual was prepared for The Governor's Council on Drug and Alcohol Abuse, Commonwealth of Pennsylvania and the Pennsylvania Department of Transportation, in conjunction with the National Highway Traffic Safety Administration, Contract #AL 76-10-4.

Project Staff responsible for the preparation of this manual were: Pascal Scoles, D.S.W., Project Director; Eric W. Fine, M.D., M.R.C. Psych., Medical Director; Michael J. Mulligan, M.Ed., Clinical Psychologist; Ms. Mary Miller, Administrative Assistant, International Alcohol and Mental Health Associates, Inc.; Louis M. Natali, Esq., First Assistant Defender, Defender's Association of Philadelphia; and Michael Byrne, Esq., Assistant District Attorney, City of Philadelphia.

FOREWORD

The purpose of this Judicial Manual is to inform the Court of recent developments which create new dispositional options for the person charged with Driving Under the Influence of Alcohol or Controlled Substances (DUI). The Pennsylvania Alcohol-Highway Safety Program does not presume to encroach upon the Court's prerogatives, but intends to provide information so that the Court's decision will continue to be based on realistic, rational, scientific data regarding the drinking driver.

Recent developments mentioned above have taken place in conjunction with legal developments regarding alcoholism treatment. They represent the culmination of efforts in the fields of medicine, psychiatry, psychology, social work, and computer technology.

The Judiciary knows only too well the burden the DUI offender places on an already strained court system and no attempt will be made to redocument established premises. The burden on the public is even greater. Suffice it to say that in any given year more Americans are killed on the highways than the total number of Americans killed in Viet Nam in ten (10) years. The significance of this statistic is underscored by the fact that one-half of these fatal accidents are related to the DUI offender.

It seems that the question we should be asking is at least two-fold: how can we best protect the public from the effects of the DUI offender; and, how can we best help the person who is before the Court for such a violation? Obviously, the questions are interrelated, because the public is best protected by the most effective disposition of the offender.

The above is especially meaningful if we ponder for a moment the reality of the DUI arrest. Police officers are rarely assigned to patrol for this particular offense. Moreover, before an officer can be said to have "probable cause" to make an arrest for DUI, he must have personally observed significant guilt-laden facts, e.g., erratic driving, an accident, etc. It seems clear that because of the burden of other duties and the difficulties of detection, law enforcement officers are only bringing the most serious cases to the Court's attention. ***As you know, alcohol-highway safety research indicates that driving skill is significantly impaired at 0.05%, even though the legal presumption is 0.10%, with the average BAC at arrest in Pennsylvania being 0.19%.***

Certainly, the Court, cognizant of all the facts about the arrest and the individual offender, is in the best conceivable position to answer the query: what is the best disposition of the DUI offender?

To facilitate the Court's decision, this Judicial Manual will discuss what the Commonwealth of Pennsylvania perceives is *new* information and data regarding the disposition and treatment of the DUI offender.

JUDICIAL STEERING COMMITTEE

The Honorable J. Sydney Hoffman (Chairman)
Judge of the Superior Court of Pennsylvania

The Honorable Joseph R. Glancey
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The Drinking Driver: An Overview

In the past 80 years the automobile has managed to gain universal acceptance as the preferred means of transportation for nearly all societies and cultures. It has also become one of the most unusual and sophisticated deadly weapons ever known to mankind. In any given year it has inflicted greater death tolls on the American public than any of the wars fought in recent times. For example, there were approximately 45,000 United States fatalities over a 10 year battle period in Viet Nam, and 52,000 highway deaths in the year of 1972 alone. The startling aspects of these highway fatalities statistics include not only the high percentage of non-driver deaths, but the fact that nearly 50% of these fatalities are considered by experts to be alcohol-related. Yet, it appears that most citizens and governmental leaders are still unaware of, or unable to respond to, the tremendous responsibility to develop innovative personal or organizational responses to this problem.

In the Commonwealth of Pennsylvania, as throughout the United States, the problem exists in various forms and, as local political practices and leadership conditions permit, countermeasures programs have become uniquely local in their responses to the drinking driver problem. In the new Motor Vehicle Code of Pennsylvania (Act 81), Driving Under the Influence of alcohol or controlled substances (DUI) is a third degree misdemeanor. On the first offense (conviction) the Department of Transportation ***must*** suspend the license for six months. If a second conviction occurs within three years, the Pennsylvania Department of Transportation ***must*** revoke the license for one year. "Habitual offenders," defined as a driver with three convictions within a five year period, incur an automatic five year revocation. All offenders can be fined up to a maximum of $2,500.

In the process of apprehension, trial and ultimate disposition of the case, all the costs, except defense, are usually directly laid on the taxpayer. According to a study by Chicago Law Enforcement Officials, the total costs of trials, jury, and prosecution expenses is estimated to be $10,000 per offender. When the costs and ultimate effects of jail and/or probation are included in the disposition process for three years, it could be safely assumed to raise that total by a substantial amount.

The costs to an offender are equally high when considering both personal and financial measures. Lawyers' fees, lost work, automobile retrieval/repair, civil suits for injuries, fines, loss of license, loss of income during incarceration, and special risk automobile insurance after the return of the operator's permit, all combine to create an extremely embarrassing financial and personal consequence of the arrest.

For the genuine "problem drinker" that exists within this drinking driver group, there is, unfortunately, usually no special program awareness of, or attention to, the unique conditions that afflict them, and they are treated "equally under the law" for their marginally controlled behavior. They may receive "special treatment" for multiple arrests (habitual offenders) if they defy the odds of a fatal accident more than once, but in most cases they receive the usual penalties unique to the arresting municipality or area. In most cases they merely consider themselves to be personally "unlucky," and take their penalties equally with their "non-alcoholic" co-offenders with little

thought or consideration to their extremely life threatening situation, and with maximum attention to the "unfairness" of their lot.

Thus, for the police, the courts, the governmental administrators, and alcohol rehabilitation workers, and the highway safety specialists, the marathon goes on and the score goes up.

But it doesn't have to be this way much longer, for the Commonwealth has now changed the rules. The keynote is revision and realization of the available evidence. The revision is in the existing laws relating to driving under the influence (DUI), and the evidence is that each drinking driver is different from the other, and that options must be expanded to meet the problem, so that prevention and protection is increased for both the offender and for society.

It is a proven scientific fact that alcohol has a definite adverse effect on a person's ability to operate a motor vehicle. According to Dr. Robert F. Borkenstein, Professor of Police Administration at Indiana University, the difference in relation to the drinking drivers can be placed in the following categories:

1) Drinking drivers who are skillful drivers but whose drinking is compulsive and uncontrolled. Consequently, whenever they drink, the alcohol concentrations are generally in the high ranges, even when they drive.

2) Drinking drivers who are not compulsive drinkers but who are overly aggressive, and as a result, are not good drivers under most circumstances. Alcohol moves them from bad to worse.

3) Drinking drivers to whom neither drinking nor driving is usually a problem. They will occasionally drive when they have had too much to drink.

4) Drinking drivers who are unusually sensitive to the effect of alcohol.

5) Drinking drivers who are learners or beginners in both drinking and driving. Their experience and skill in each area is limited and therefore their driving behavior may be uncertain and unpredictable. This class includes some teenagers.

6) Drinking drivers who because of age or illness are losing or have lost their driving skills. Alcohol accentuates this loss of skill.

7) Drinking drivers who have no problem with drinking or with driving. They conscientiously and consistently manage to be below the threshold of impairment from alcohol for them when they drink and then drive.

There is steadily mounting evidence to show that drinking drivers in category one are involved in a disproportionate number of fatal crashes. With their consistently high blood alcohol

concentrations when drinking and driving (evidence of problem drinking or alcoholism), they are a menace to themselves and to others.

This fact was underscored in the ***1968 Alcohol and Highway Safety Report to the United States Congress.*** That report states: "Alcoholics and other problem drinkers who constitute but a small minority of the general population account for a very large part of the overall problem."

In a report from the Advisory Committee on Traffic Safety to the Secretary of Health, Education and Welfare, it is stated that: "The overwhelming weight of evidence is that alcoholism plays a very substantial role, and probably the major role, in the occurrence of traffic accidents involving the use of alcohol."

This is what this manual is about; a new look at an old problem. We hope that you as a lawyer, and a potential victim, will be able to use your new impressions to prevent and protect yourself, your family, and your community. ***Most importantly it cannot be done on a single person level or even with one agency or department. To respond to this problem will require a concerted, cohesive and cooperative agreement between the police, judiciary, and rehabilitation personnel, with mutual concern and trust necessary to achieve a common goal.***

How Alcohol Affects the Driver

Alcohol affects all the cells of the body, but the most dramatic results of ingesting ethyl alcohol occur in the nervous system. The central nervous system, especially the brain, is primarily affected by alcohol, with an early apparent stimulation resulting from depression of inhibitory control mechanisms. Discrimination, insight, memory, concentration, and perception are all dulled by alcohol, while speech may become eloquent, and mood swings uncontrolled. Complex behavior patterns are released that depend essentially on the personality of the individual, external stimuli from the environment, and tolerance for the drug. Alcohol seriously diminishes both mental and physical abilities, although when under its effect people typically overestimate their performances. For any given blood alcohol level, the effects of alcohol are more noticeable when the alcohol concentration in the blood is rising than when it is falling. High levels of alcohol concentrations affect the ability to discriminate between lights of different intensities. Narrowing of the visual field occurs and may be particularly dangerous in automobile driving. Resistance to glare is impaired so that the eye requires longer to readjust after exposure to bright lights. Sensitivity to certain colors, especially red, appears to decrease.

Although the question of the effect of alcohol on gross behavioral change is not yet fully resolved, the results are unanimous in showing that driving skills already begin to deteriorate at blood alcohol levels below 0.05%. This level of alcohol in the blood would be reached, broadly speaking, in a person weighing 190 lbs. who had consumed three (3) 12-ounce beers, or three (3) cocktails containing one ounce each of 86 proof alcohol, within one hour before driving. Although other factors, such as the presence of food in the gastrointestinal tract, influence the rate of entrance of alcohol into the bloodstream, a 120-pound person would achieve a blood alcohol level

of 0.05% with less than two (2) 12-ounce bottles of beer or less than two (2) cocktails containing an ounce of 86 proof alcohol each.

Increasing concentration of alcohol in the blood is related to a number of driving errors, e.g., carelessness, reduced exactitude in steering and braking, more frequent stalling at critical moments, etc. A concentration of 0.05% alcohol in the blood produced a tendency to drive toward a road ditch in 82% of the cases studied. With 0.10% blood levels, drivers consistently fluctuated between low and high speeds, swerved from lane to lane, and used excessive amount of time to return to the correct lane. Blood alcohol levels of 0.10% adversely affect normal driver performance by 15%, with deterioration increasing to 30% with blood alcohol levels of 0.15%.

There is no question that the percentage of vehicle accidents increases sharply as the driver's blood alcohol level increases. The chance of accident involvement where blood alcohol levels are between 0.05% and 0.10% is two to seven times greater than persons at zero BAC, and at 0.15%, it is approximately 25 times greater. These estimates are given indirect support by studies which show a positive correlation between blood alcohol levels and other serious relevant variables, such as extent of damage, expense of damage, and severity of injury.

Psychological Factors in Drinking Drivers

While numerous studies have established that problem drinkers have higher rates of alcohol-related accidents than social drinkers, considerable controversy still exists concerning the responsible factors. Some authorities argue that physiological impairment caused by excessive alcohol intake is the most important factor, while others feel that personality characteristics, such as impulsiveness, hostility and suicidal tendencies exacerbated by alcohol are most significant. It is most likely that a complex interaction of these variables in a particular individual results in a person at high risk of becoming involved in an automobile accident. Personality factors in problem drinkers are presumed more important than sensorimotor impairment, while in younger non-alcoholic drivers with the same blood alcohol levels, impairment of sensorimotor functions is primarily responsible.

A full understanding of the problem of the drinking driver requires intensive study of the demographic, social and psychological characteristics of the persons involved. The personality traits observed in intoxicated persons involved in accidents include chronic hostility, depression, feelings of omnipotence, invulnerability, self-destructiveness, egocentricity and decreased tolerance to tension. The significance of suicidal tendencies, unconscious or otherwise, has received particular attention.

Alcohol intoxication might thus be responsible for automobile accidents not only because it impairs sensorimotor functions, but also because of its potential for reducing emotional control and releasing self-destructive impulses. Certain combinations of personality difficulty are highly predictive of accident potential, and in problem drinkers it appears that an interplay between social or psychological stress, deleterious personality traits which are liberated by alcohol, and the impairment of skill caused by intoxication, is responsible for an excess of traffic accidents in which death may occur.

In summary, it can be stated that tests of overall driving ability become meaningless if only psychomotor concepts are considered. Equally important are the effects of alcohol in reducing inhibitions, altering self-perception and self-confidence, and changing attitudes and value judgments.

The Management of Drinking Drivers

The effective management of the population that drinks and drives automobiles is extremely complex, particularly since a significant proportion of DUI offenders have serious alcohol abuse problems over and above that associated with the driving offense. ***It is highly probable that the great majority of these persons would never have been exposed to public scrutiny or intervention for their drinking behavior had they not been arrested for DUI. Thus, we have a captive audience of individuals with drinking difficulties.***

Alcoholism itself is not a unitary condition, the "alcoholic population" in any community consisting of a large variety of subgroups with many different problems underlying, or secondary to, their dependency on alcohol. Thus, no one type of treatment approach will be applicable to all these groups, and successful management depends on an accurate delineation of the specific drinking syndrome and the organization of appropriate treatment regimens.

Clinical experience strongly suggests that specific treatment techniques will have to be developed for those persons who drive under the influence (DUI). These may be considerably different from those typically employed in the general field of alcoholism. It is not sufficient for the majority of these subjects to be merely referred to existing alcoholism treatment programs or self-help groups such as Alcoholics Anonymous, as many of them require complex services providing a wide range of treatment modalities, and not just a traditional total abstinence approach. ***The inability of many criminal justice systems to view DUI offenders as primarily a public health problem has allowed the legal system to operate on a punitive, short-term basis, using indirect punishment such as provoking job loss, fines, jail sentences and license suspension as "preventive" techniques.*** This approach is intended to reprimand the individual for his deviant behavior, and thereby protect society from a recurrence of that behavior, but frequently only exacerbates the problem.

Highway Safety research indicates that these methods have had a minimal effect. License suspension, or revocation, is not an effective deterrent. Incarceration is a very expensive and burdensome legal procedure, filling correctional facilities with individuals who seem impervious to short-term jail sentences. At best, it contributes to job loss, which probably increases the chance that alcohol abusers will drink more heavily and therefore be more likely to precipitate traffic accidents. Also, recent figures from California have demonstrated that, in that state, more than one-third of first offenders and one-half of second offenders are ***convicted again*** for driving violations ***while under suspension or revocation of license.***

The implications of these facts are clear: law enforcement techniques alone are not sufficient to deter repeated drinking driving offenses, and this failure has contributed to an annual rate of

almost ***30,000 deaths*** and ***15.8 billion dollars*** in property damage and personal injury. ***The above figures, coupled with the offender's attitude, should force the criminal justice system to re-examine the evidence and develop a special compulsory treatment system that is closely linked to an effective and cooperative judicial system.*** It is evident, however, that simply to remove this problem from the singular purview of the law will not be effective if appropriate socio-psychological rehabilitation systems do not exist. On the other hand, some ultimate legal sanction must exist to buttress treatment efforts. ***Second and third offenders must be brought to the realization that a failure to accept treatment, and all of its implications, will ultimately result in incarceration.***

In a system which involves the law profession and mental health professionals, there always exists the basic conflict between treatment and punishment. Changing behavior for the benefit of the community should be the mutual objective of both professions, but neither alone has been as effective as it would like to be in accomplishing this. ***Driving under the influence of alcohol is a classic example of a public health problem that necessitates the creation of a working relationship between the judicial and mental health systems for its effective management.***

There are indications that a combined legal-mental health approach would be a viable alternative to punishment, and would enhance the chances of successful rehabilitation. Previous studies dealing with court-committed treatment of some more seriously deteriorated alcoholics have shown an average success rate of 50%. The therapeutic approach would have the same primary goal as the legalistic approach, i.e., of protecting society by preventing the individual from repeating his deviant behavior. Its process would be different, however; it would constructively guide the individual toward a changed pattern of behavior, so that he might exist as a well-functioning element within society.

Considerations for Treatment and Rehabilitation

A. *Diagnosis and Evaluation*

The DUI population has been shown to be heterogenous, and in all probability consists of a number of subgroups, most of which can be classified as problem drinking types. There is, of course, the possibility that a so-called "social drinker" might be arrested for DUI on the basis of an occasional, or even isolated, incident of alcohol abuse. Most research would agree that a significant proportion of DUI offenders can be classified as "problem drinkers" or "alcoholic persons." Depending on the particular group of DUI offenders studied, and the definitions used, this proportion of problem drinkers can range from 50-70% of the studied populations. It might be argued that anyone arrested for DUI has a "drinking problem" of some importance.

The objective of a diagnostic evaluation is to formulate as effective an individualized countermeasure/rehabilitation plan as possible for each DUI offender. This outcome depends upon an accurate delineation of the individual's drinking pattern, personality profile, and general lifestyle. ***The legal system must recognize that evaluation is one of the most critical factors because it enables the Court to sentence more intelligently.***

1) ***Evaluation Instrument*** – Several of these are available, including the Mortimer-Filkins Test; the Michigan Alcoholic Screening Test (MAST); the Short Michigan Alcoholic Screening Test (SMAST); National Council on Alcoholism (NCA) Criteria for the Diagnosis of Alcoholism; and Johns Hopkins Alcoholic Screening Test. Of these instruments, the most readily available, generally useful, and comprehensive is the Mortimer-Filkins Test.

All of these instruments are intended to provide an objective evaluation of the DUI offender with special reference to the drinking behavior. The use of such objective instruments is far superior to a more subjective and potentially biased individual impression. All of these instruments do depend, however, on a degree of accuracy and truthfulness on the part of the interviewee. ***In order to obtain some degree of standardization throughout the Commonwealth, it has been strongly recommended that the Mortimer-Filkins Test be adopted as the routine testing measure for countermeasures programs.***

2) ***Additional Evaluative Indicators*** – There are several supplementary tools that may increase the predictive and diagnostic qualities of the primary measurement instrument. These are as follows:

a) ***Blood Alcohol Concentration (B.A.C.)*** – This is calculated from a measurement of the alcohol content of a sample of expired air from the offender. There is a predictable and constant ratio between the alcohol level in the blood and that in the alveolar air of a subject. It should be noted that a BAC of more than 0.10% in a routine examination is regarded by the Criteria Committee of the National Council on Alcoholism as being clearly and definitely ***associated*** with alcoholism. This would imply that every offender arrested for DUI at 0.10% should be ***considered*** in a category of alcoholism unless proven otherwise by additional considerations. On this basis, it would certainly seem reasonable to suppose that any person who has been arrested with a BAC of 0.15% or more could be automatically regarded as a serious "problem drinker."

b) ***Previous Arrest Record*** – Any previous arrest for DUI or other alcohol-related offense within the preceding five years should be regarded with a high index of suspicion as suggestive of an "alcoholic person."

c) ***Self-Admitted Problem*** – A person voluntarily admitting to "loss of control" over alcohol consumption would lend strong suspicion to the diagnosis of alcoholism.

d) ***Previous Treatment for Alcoholism or Social Problems Related to Alcohol Use*** – A person's self-described or known history of any alcohol-related medical, psychological, or social condition should also be regarded as extremely significant in the diagnosis of alcoholism.

e) ***Measurement of Client Truthfulness*** – It is reasonable to suppose that some of the information obtained from DUI clients may be inaccurate. This could result from deliberate attempts to mislead the interviewer, or in the case of serious alcohol dependency, organic impairment of the brain producing amnesia, alcoholic "blackouts," or inaccurate recall. It is also commonly accepted that many "alcoholic persons" develop extreme denial mechanisms regarding their drinking behaviors and their significance. A number of aids to assess "lie factors" are available. The "Alco-Calculator" can be used to compare police-reported BAC with the client's report of the number of drinks consumed prior to arrest. Should there be a marked discrepancy one can assume

misreporting. The ***Eysenck Personality Inventory (E.P.I.)***, a quick and simply administered and scored instrument, has a specific built in measure of "faking good" responses, and could be incorporated into the interviewer's overall perception of "truthfulness."

Collection of Utilization of Diagnostic Findings –
DUI Countermeasures Summary Report

Upon interview completion and the assembly of relevant informational elements, it will then be necessary to compile a summary report containing three major sections: a diagnostic description of suspected degree of alcoholism; a profile of the offender; and recommendations for follow up and disposition.

It must be strongly emphasized at this point that the accuracy of any report is strongly influenced by the quality of the data that is incorporated in its construction. The computer programmer's adage "GIGO" ("garbage in, garbage out") is an especially important consideration for all programs. If any program of alcohol countermeasures is to succeed, it must have an extremely high level of credibility among all levels of the community, from the DUI offender to the highest court official. Therefore, it must be assumed that all elements of data are meticulously protected to insure that every item, from police Breathalyzer report, to the signature on the final report, is objective, accurate, and free from any personal or subjective influences.

While the degree of objectivity of any program that attempts to incorporate highly selective and isolated behavioral events in making a prediction about a person can certainly be attacked as lacking in total scientific validity, it must be argued that successful rehabilitation (and thus prevention) has been reported in some circumstances to be as high as 80% of the cases treated for alcoholism from less impaired groups in industrial settings. This can be contrasted to a California study that showed as many as two-thirds of drivers with revoked licenses (a non-treatment alternative) were known to continue to drive, since they were identified through subsequent arrests or accidents for driving while under revocation. Thus, in the absence of complete, and all-encompassing accuracy, it does appear that an identification and rehabilitation process would be no less effective than the present maximum license penalty under the Pennsylvania Motor Vehicle Code (Act 81).

There are several underlying assumptions that must be made in any recommendation to send a person for treatment for alcoholism. Many of these are commonly accepted by most persons, but several are quite controversial even among very knowledgeable alcoholism professionals. Few will argue that many persons appear to have problems in maintaining control over their use of alcohol. It is also commonly accepted that this "loss of control" phenomenon is not absolute, and varies in degree among different individuals and from time to time. The causes of alcoholism and a singularly successful cure have not been determined at this time. It has been the experience of many persons, both recovering alcoholics themselves, and professionals within the treatment community, that

alcoholism can be "treated" with reasonable success and that the symptoms that surround it can be significantly reduced in many cases.

Care must also be taken that no confusion is made in understanding that ***remission of symptoms*** is ***not the same as a cure***. The Governor's Council on Drug and Alcohol Abuse, as well as numerous other national statistics and authorities in the field, concede that, at this time, most forms of alcoholism must be considered to be a life-long condition, and numerous relapses and vehement denial are outstanding characteristics of the condition. Thus, many claims of various proponents of specific and universal "cures" must always be regarded with extreme suspicion by any referring agent. However, many techniques and therapies are quite effective for certain persons when they correspond to their ideals and acceptance levels, and significant changes in behavior can frequently be expected when conditions are suitable for such changes.

Experience both in the field of alcoholism treatment and that of alcohol highway safety has demonstrated that any treatment program must be flexible enough to allow for individual needs, and must have available several modalities of treatment which can be used in multiple combinations. The reason for having such an approach is based on the knowledge that people arrested for DUI, and who may also be problem drinkers, do not constitute a homogeneous group, and therefore might require quite different treatment regimens with extremely different expectations. There is no doubt, for example, that the degree of problem drinking varies from those offenders who are borderline, so far as diagnosis is concerned, to those individuals whose history and examination leave no doubt that they are alcohol addicts.

Some modalities that have been described as especially useful in the treatment of alcoholism are: Group Therapy, Individual Therapy, Family Therapy, Disulfiram (Antabuse®) Therapy, Chemotherapy, and many others. The environment in which these therapies can be best administered is usually determined by an evaluation of patient needs and the availability of communicty resources. ***In general, it has been the experience of most DUI Treatment Programs, that an outpatient environment is quite adequate for the majority of DUI patients, but supportive availability of inpatient, detoxication, and residential care units may be of great value.***

In conclusion, it should be noted that there are few organized and coordinated systematic treatment programs for DUI offenders in Pennsylvania. In the City of Philadelphia, as a result of some basic research and experience, a need was demonstrated for a treatment program specially designed for DUI problem drinkers, and in 1976 four such special treatment programs are in existence. Also, in Reading, a need for treatment services was recognized, but because of the relatively small number of offenders, their objectives were accomplished within the structure of existing alcoholism treatment programs. In both these cities, the identification and evaluation of the DUI population has resulted in very substantial increases in the referral and admission of alcoholic persons to these alcoholism facilities. In most of Pennsylvania however, there is not only a paucity of alcoholism treatment services in general, but a critical stortage of services for specific groups of alcoholic patients, such as alcoholic DUI offenders.

Throughout the Commonwealth there is a limited number of Alcohol Highway Safety Countermeasures Programs, but the existing programs are, in nearly all cases, essentially educational

in nature and do not emphasize, nor conduct, specific treatment on a formal basis. If treatment is mentioned at all it is within the context of a group experience and it is invariably simply a referral or suggestion to attend an Alcoholics Anonymous open meeting, which for most DUI offenders who are earlier stage problem drinkers, may be an inappropriate modality. This is partly because of the anonymity required within the organization itself, which, by organizational philosophy, prohibits developing an accurate recording and reporting between Alcoholics Anonymous groups and the criminal justice system.

Another problem is that most existing alcoholism treatment systems emphasize inpatient treatment, which does not seem to be the most appropriate environment for the vast majority of the alcoholic DUI offenders. The experience of pilot and developing programs strongly supports the notion that these persons require ***outpatient approaches*** that are specially tailored to their needs. Treatment programs for these persons will have to relate to the special conditions of this group, that reflect their special characteristics and needs.

Current research with the DUI population suggests that these persons are, generally speaking, less alcohol-impaired than the type of patient usually seen in alcoholism treatment programs. They are typically male, more often married and living with their spouses, more likely to have good employment records with continuous employment, and have shorter histories of problem drinking than customarily seen in generally voluntary admissions to alcoholism treatment. Although these characteristics would suggest a better prognosis, they are counterbalanced by a significantly poorer motivation to attend and commit oneself to an enduring treatment plan. It is, therefore, very important that a treatment program become mandatory and that the full support of the criminal justice and probation system be mobilized to ensure offender participation in treatment.

The results of a pilot demonstration program for alcoholic DUI offenders conducted in Philadelphia in 1975, suggested that, for meaningful behavior changes to occur, once weekly treatment for six months is the minimum involvement, and it would probably be more desirable to insist on approximately one year of weekly therapy sessions to more fully implement significant, long-lasting behavior change.

Any treatment program for alcoholic DUI offenders should be seen as an integral part of a total system, under the control and leadership of the courts. The treatment system must link with, and provide continuity of care from the judicial, probation and parole, and educational components, and should also be closely allied to existing alcohol and general health care delivery systems. There are many different ways in which this could be accomplished, and in each community the DUI treatment system should become part of the local health care delivery system with special ties to both Drug and Alcohol, and Mental Health Programs. ***The vitally important part played by the local criminal justice system, which will include police, judges, prosecutors, defenders, and probation and parole officers cannot be overemphasized.***

Past, Present, and Future Directions for DUI Countermeasures

Over the past 80 years of driving legislation, there have been few attempts to legislate DUI prevention into the Motor Vehicle Code of Pennsylvania.

The National Highway Traffic Safety Administration (NHTSA) has for many years studied the problem of the drinking driver. NHTSA's recommendations were included in the model traffic code known as the Uniform Motor Vehicle Code which has served as the base for the newly enacted Pennsylvania Motor Vehicle Code of 1976, which significantly updates the law in nearly all aspects of traffic safety.

It is now apparent that a more balanced approach to the problem will be adopted, with the recognition that the criminal justice system and the treatment and rehabilitation systems must become partners in any meaningful efforts to reduce the effects of this major public health problem.

Some technological developments are sure to have a marked effect on DUI detection and rehabilitation in the coming decade. The increased organization and standardization of DUI countermeasures in Pennsylvania is sure to have a marked effect on the development of improved administrative and clinical procedures in the management of the problem. Some possible approaches in treatment would include mandatory disulfiram therapy for repeat or resistant offenders, increased use of weekend or evening incarceration, and extensive use of Accelerated Rehabilitative Disposition (A.R.D.). Also, the use of sophisticated breath analysis techniques should be encouraged in all programs involved in evaluation, treatment, and rehabilitation of selected DUI offenders. Such technology will help to refine diagnosis, and objectify and standardize alcohol abuse behaviors. This will facilitate clear communication, and therefore foster relationships between rehabilitation staff, the courts, and the DUI offender. Technology advances are especially important in the use of accurate and understandable measures of condition and progress shared by the therapist with the client.

Of great significance is the growing emphasis on the quality of alcoholism treatment facilities themselves. Standards for operation and licensing as well as national accreditation for alcoholism treatment programs are now a reality. It is also apparent that this process will accelerate the demise of many marginal and ineffective programs and encourage high administrative and clinical standards for the surviving few. Any form of national health insurance is sure to be linked to the most advanced treatment systems, and payment for any such services will certainly be associated with accredited programs with strong outpatient and aftercare elements.

Program Interrelationships

While there are clearly differences in programs operating within the various communities in the Commonwealth, it is apparent that some basic elements must always exist in order to conduct any

effective countermeasures program; simply stated, they are law enforcement, judiciary, and rehabilitation. The following flowchart is provided to give a graphic illustration of a fully functioning and comprehensive countermeasures program in the Commonwealth of Pennsylvania.

PENNSYLVANIA ALCOHOL-HIGHWAY SAFETY PROGRAM (PAHSP)

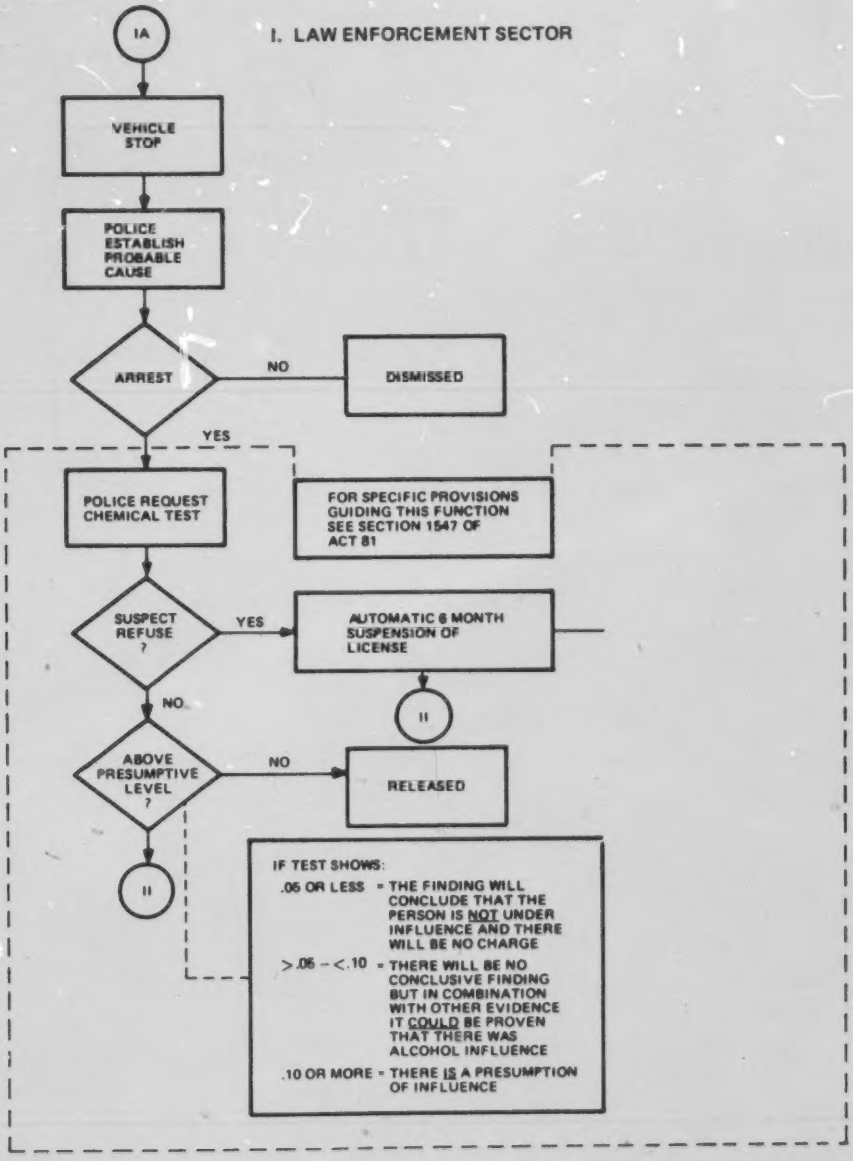
FLOWCHART

I. LAW ENFORCEMENT SECTOR
   - IA. Arrest Process

II. JUDICIAL SECTOR
   - IIA. District Attorney Pre-Trial Screening
   - IIB. Trial Proceedings
   - IIC. Post-Diagnostic Court Ruling

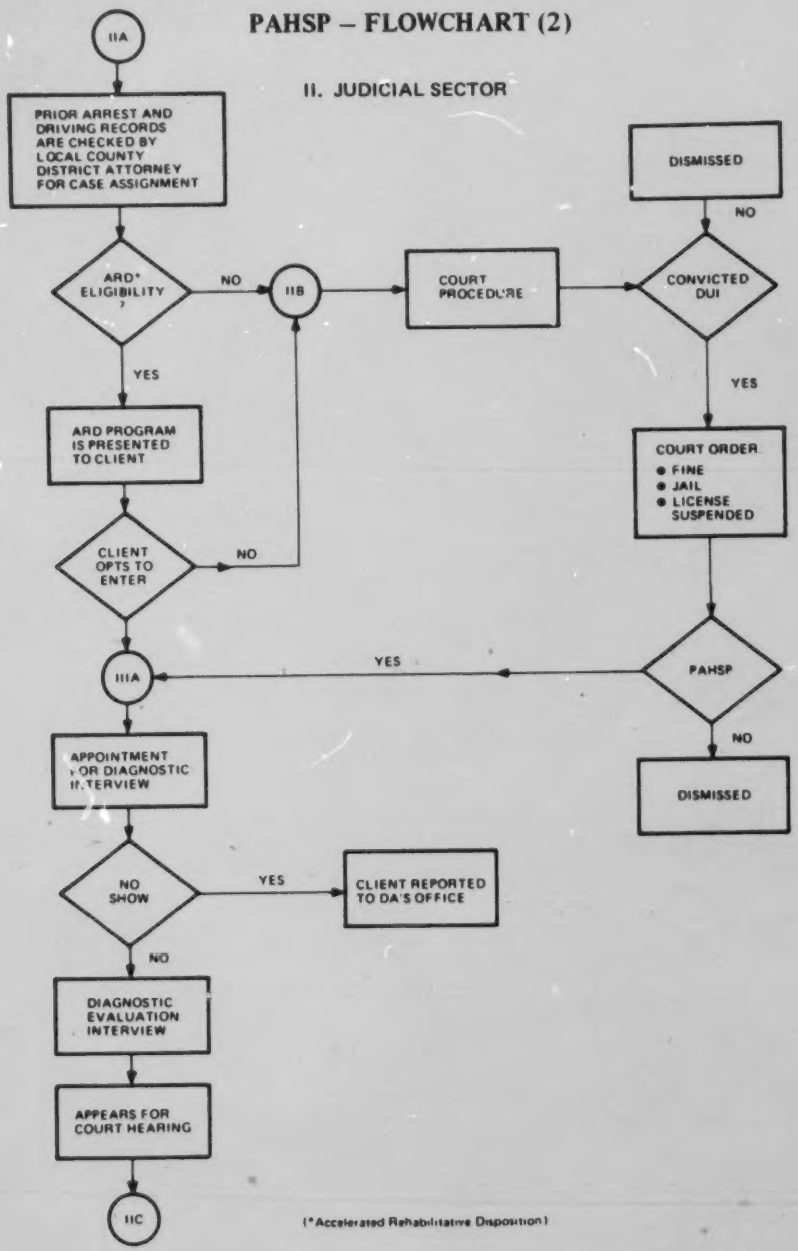
III. REHABILITATION SECTOR
   - IIIA. Diagnostic Evaluation
   - IIIB. Psycho-Medical Treatment
   - IIIC. PAHSP Safe Driving School

PAHSP – FLOWCHART (1)


I. LAW ENFORCEMENT SECTOR
IA
VEHICLE STOP
POLICE ESTABLISH PROBABLE CAUSE
ARREST
NO
DISMISSED
YES
POLICE REQUEST CHEMICAL TEST
FOR SPECIFIC PROVISIONS GUIDING THIS FUNCTION SEE SECTION 1547 OF ACT 81
SUSPECT REFUSE ?
YES
AUTOMATIC 6 MONTH SUSPENSION OF LICENSE
II
NO
ABOVE PRESUMPTIVE LEVEL ?
NO
RELEASED
II
IF TEST SHOWS:
.05 OR LESS = THE FINDING WILL CONCLUDE THAT THE PERSON IS NOT UNDER INFLUENCE AND THERE WILL BE NO CHARGE
>.05 – <.10 = THERE WILL BE NO CONCLUSIVE FINDING BUT IN COMBINATION WITH OTHER EVIDENCE IT COULD BE PROVEN THAT THERE WAS ALCOHOL INFLUENCE
.10 OR MORE = THERE IS A PRESUMPTION OF INFLUENCE

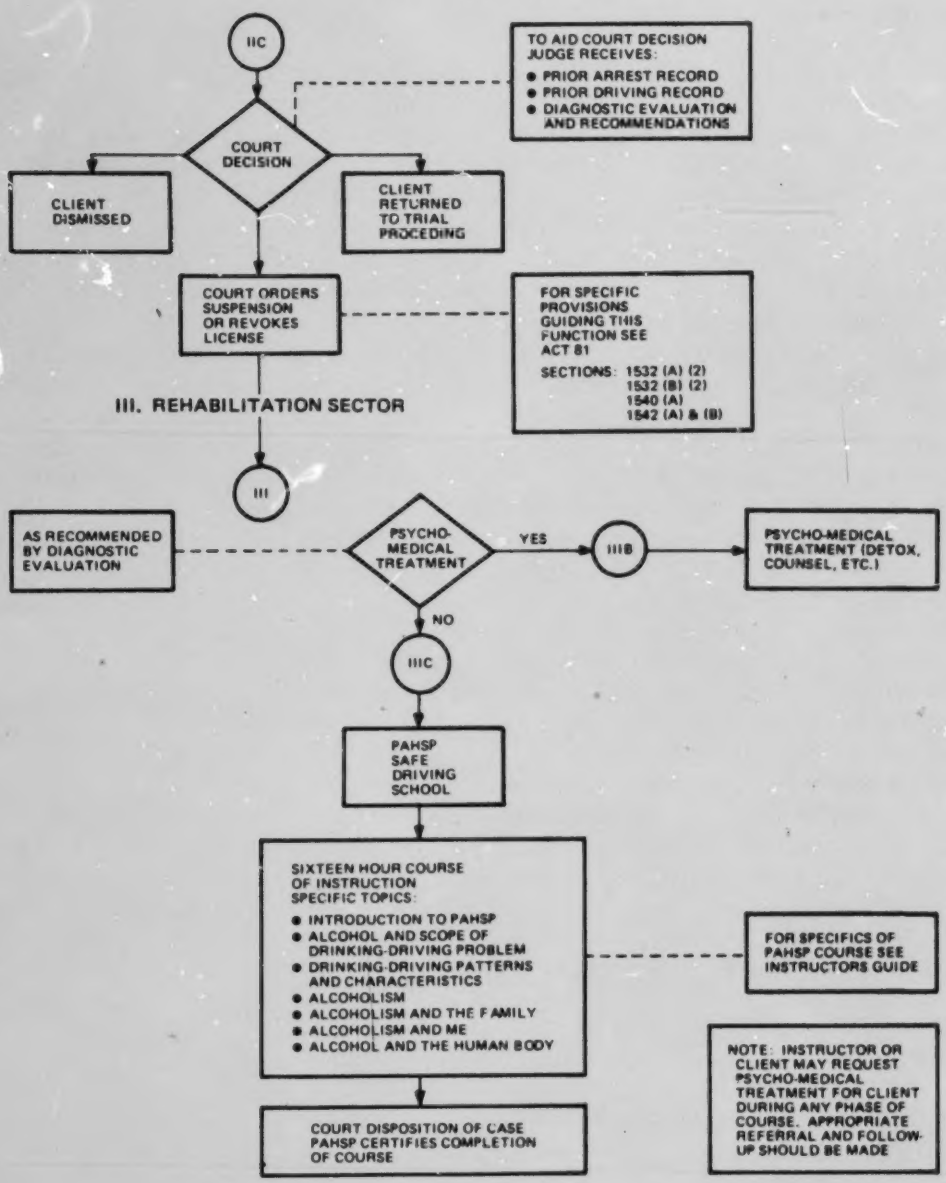
PAHSP – FLOWCHART (2)

II. JUDICIAL SECTOR



(*Accelerated Rehabilitative Disposition)

PAHSP – FLOWCHART (3)


IIC
TO AID COURT DECISION JUDGE RECEIVES:
• PRIOR ARREST RECORD
• PRIOR DRIVING RECORD
• DIAGNOSTIC EVALUATION AND RECOMMENDATIONS
COURT DECISION
CLIENT DISMISSED
CLIENT RETURNED TO TRIAL PROCEDING
COURT ORDERS SUSPENSION OR REVOKES LICENSE
FOR SPECIFIC PROVISIONS GUIDING THIS FUNCTION SEE ACT 81
SECTIONS: 1532 (A) (2)
1532 (B) (2)
1540 (A)
1542 (A) & (B)
III. REHABILITATION SECTOR
III
AS RECOMMENDED BY DIAGNOSTIC EVALUATION
PSYCHO-MEDICAL TREATMENT
YES
IIIB
PSYCHO-MEDICAL TREATMENT (DETOX, COUNSEL, ETC.)
NO
IIIC
PAHSP SAFE DRIVING SCHOOL
SIXTEEN HOUR COURSE OF INSTRUCTION
SPECIFIC TOPICS:
• INTRODUCTION TO PAHSP
• ALCOHOL AND SCOPE OF DRINKING-DRIVING PROBLEM
• DRINKING-DRIVING PATTERNS AND CHARACTERISTICS
• ALCOHOLISM
• ALCOHOLISM AND THE FAMILY
• ALCOHOLISM AND ME
• ALCOHOL AND THE HUMAN BODY
FOR SPECIFICS OF PAHSP COURSE SEE INSTRUCTORS GUIDE
NOTE: INSTRUCTOR OR CLIENT MAY REQUEST PSYCHO-MEDICAL TREATMENT FOR CLIENT DURING ANY PHASE OF COURSE. APPROPRIATE REFERRAL AND FOLLOW-UP SHOULD BE MADE
COURT DISPOSITION OF CASE PAHSP CERTIFIES COMPLETION OF COURSE

Amendments to Pennsylvania Motor Vehicle Code Regarding DUI Offenses – (Act 81)

In the final days of the 1976 session, our legislature enacted a new and comprehensive vehicle code. The following key provisions are noted in the existing law:

1) ***Third Degree Misdemeanor:*** Section 3731 defines the offense as a third degree misdemeanor. The basic definition of influence remains intact but a combination of alcohol and drugs rendering a person unable to drive is specifically described. Section 3731(9)(1).

Subsection (c) also amends prior arrest law because it authorizes the arrest of a DUI offender based on probable cause even if the officer has not personally observed the offense. Under common law rules, no arrest can be made for a misdemeanor unless personally observed by the officer and based upon a judicially issued complaint or warrant.

Under the new Act, an officer can arrest a person based upon other guilt-laden facts, i.e., an accident, without the arresting officer's personal observation. Prompt arrest immediately erects an obstacle to continued driving.

2) ***Penalties:*** Fines of up to $2,500 and one year in prison can be assessed for an offense. In addition, pursuant to Section 1532(a)(2), (b)(2), ***first*** offenders receive a ***six month license suspension.*** A ***second*** conviction within three years will result in a ***mandatory one year revocation.***

3) ***Accelerated Rehabilitative Disposition (A.R.D.):*** Section 1534 specifically permits the use of ARD for violations of Section 3731. However, use of ARD will effect a subsequent suspension as provided by Section 1539(c).

4) ***Surrender of License:*** Section 1540 mandates a court-ordered surrender of driver's license together with a return to the Department of Transportation.

5) ***Habitual Offenders:*** Section 1542(a) and (b) defines as a habitual offender any person thrice convicted of DUI within a five year period. Such a person is subject to an ***automatic five year revocation.***

6) ***Pre-Sentence Examination:*** Any person ***twice*** convicted of DUI within five years ***must*** be given a pre-sentence investigation pursuant to Section 1548(a). In addition, the Court under subsection (b) may require treatment at a facility approved by The Governor's Council on Drug and Alcohol Abuse. Said commitment is subject to review upon the filing of a petition.

7) ***Establishment of School:*** Section 1549(b) provides for the establishment of a school or schools throughout the Commonwealth to provide instruction on problems of alcohol and driving.

8) ***Presumptions and BAC Tests:*** Section 1547 provides for the administration of BAC tests. Consent for such a test is deemed to be given by the acceptance of a driver's license. Refusal to submit to a test results in an automatic suspension for six months. A second refusal results in an automatic one year suspension. The tests may, upon request, be administered by one's personal physician.

0.05% or below is conclusive evidence that a person is ***not*** under the influence. Section 1546(d)(1).

In excess of 0.05% but below 0.10% creates no presumption, but permits the offense to be considered with other competent evidence in determining the issue of whether the person was or was not under the influence. Section 1547(d)(2). In excess of 0.10% creates a presumption that the person was under the influence. This presumption is, pursuant to subsection (d), a rebutable presumption.

For the first offense, the defendant or his attorney, is entitled to the offender's test results ***prior*** to trial. Section 1547(f).

Under subsection (i), a driver involved in an accident may request the BAC test and it shall be honored if "reasonably practicable to do so."

The Educational Function and Its Relationship to the Comprehensive Plan for DUI Countermeasures

Pursuant to Section 1549, an educational program on the problems of alcohol and driving will be established and maintained throughout the Commonwealth of Pennsylvania. This revolutionary enactment reflects the legislative recognition of the role education can play in counteracting DUI offenses. The statute provides for a uniform course of instruction by faculty certified by the Department of Transportation.

The Pennsylvania Alcohol-Highway Safety Program's DUI Safe Driving School will provide sixteen hours of class instruction in weekly two-hour segments. The two major goals of the school are: (1) an increase in awareness and knowledge regarding alcohol, alcoholism, and highway safety; and (2) a change in attitudes regarding driving under the influence.

The rationale for the DUI Safe Driving School is based on an assumption that an individual who consumes alcohol, and in particular "drinks and drives," has a fundamentally positive attitude toward alcohol consumption. In general, he perceives drinking as beneficial, and uses positive phrases such as "It tastes good," "It takes the hurt out of my bones," "I have more fun when I drink," "It helps me forget about my worries," etc. Surprisingly, and yet in keeping with cognitive dissonance theory, few, if any, of the deleterious effects of drinking alcohol are discussed by the offender (student). The admittance to self and others that one's drinking behavior has negative and at times grave consequences for oneself would create for the individual internal conflicts, and would perhaps result in a decrease in their drinking. Therefore, an individual who drinks, continues to do so primarily because he continues to maintain a positive position of thinking, feeling, and acting as if alcohol were conducive to his good health. Furthermore, he drinks (defined as an individual who drinks and actively desires to continue his drinking at some level) via an elaborate ritual, the intention of which is to deny to himself in some manner to introjection of negative data concerning alcohol use. His denial of the negative aspects of alcohol is accomplished through an elaborate cognitive-emotional process. This process promotes the "goodness" of alcohol (acts, events, situations, felings, thoughts, etc.) and does not allow the negative to be felt or known, through the

utilization of such mechanisms as repression, denial, suppression, projection, selective perception, reaction formation, forgetting, etc. ***In summation, alcohol consumers accentuate the positive and ignore the negative regarding their alcohol use.***

Applying cognitive dissonance theory to the phenomenon described above, the DUI safe driving classes emphasize some of the negative aspects of drinking and driving. To facilitate change in drinking behavior, one must first create dissonance – i.e., conflict – in the individual's attitudes and beliefs regarding his drinking behavior. One can assume that first offenders arrested for DUI will attend class feeling generally that their drinking behavior is positive. Most offenders feel that the fact that they were arrested is more important than their alcohol consumption. This persistence and, in reality, rigid thinking and behavior must first be challenged in order to begin the process of change. This can be accomplished by presenting data that attest to the negative qualities of drinking alcohol. If this is done through the utilization of information (valid, reliable, and believable), a possible conflict situation (dissonance) will result within the individual, i.e., two sets of contradictory information about the same issue (alcohol).

However, because of the offender's rigid thinking and behavior, the individual may not incorporate the new data, since inconsistent and dissonant behavior creates conflict – which is, of necessity, threatening and anxiety-provoking. Innumerable psychological studies attest to the fact that people, in general, develop defense mechanisms to avoid feeling anxious. Knowing this occurs, one must attempt to introduce these dissonant facts about alcohol in the context of a warm, supportive and accepting climate which will help to reduce the level of threat. In the DUI classes, an attempt will be made to motivate the individual by creating tension through cognitive dissonance while maintaining a non-threatening external class climate to facilitate and support new thinking and behavior. Since change involves both cognitive and emotional processes, it is important that an individual's emotional component, his "feelings" regarding his drinking behavior, as well as his cognition, be utilized and integrated into his/her change process.

For your information, the lesson plans for the eight sessions are noted below:

Lesson Plan I – Introduction to Pennsylvania Alcohol – Highway Safety Program.

Lesson Plan II – Alcohol and the Human Body.

Lesson Plan III – Nature and Scope of Drinking Driving Problem.

Lesson Plan IV – Drinking and Driving Patterns and Characteristics.

Lesson Plan V – The Problem Drinker/Alcoholism.

Lesson Plan VI – Alcoholism and Family Disruption.

Lesson Plan VII – Alcoholism and Me.

Lesson Plan VIII – Review of DUI Educational Safe Driving Program.

The Role of the Legal System

While it appears that the detecting and treating professions have made enormous strides in fulfilling their ordained functions, the legal system has merely marked time. Prosecutors may seek the application of rigid formulae, e.g., probation for the first offender, a short jail sentence for the repeater, and lengthy incarceration for the hardcore DUI offender.

Defense attorneys still think in terms of winning rather than the long-term best interest of the client, and the judiciary is still strapped with rather inflexible sentencing options.

The law profession should ponder the sobering thought that the legal system ***alone*** has done very little to deter drinking driving, despite the fact that the criminal justice system possesses a captive audience.

A) ***The Use of Prosecutorial Discretion***

The prosecutor stands in the best position to change the pattern of disposition. This can be accomplished in several ways:

(1) ***The Decision to Use ARD***

By opting not to prosecute the case, but to dismiss it conditionally, the prosecutor has removed another burdensome case from the docket and foreclosed the possibility of incarceration and its additional expense. But more importantly, by rapidly disposing of the legal side of the problem, he has helped to begin the treatment process at an early stage. It is not absurd to say that often a litigated DUI trial can, including motions to suppress, trial and appeal, take years. Little advantage is obtained for either the drinker or the public because the offender continues to drive without treatment.

(2) ***The Post-Verdict Decision to Order Treatment***

While the Court is well aware of the heavy and lonely duty facing it, often, it seeks and relies upon the prosecutor's recommendation. At this point, a recommendation for treatment can "tip" the decision in that direction. Considering the cost of incarceration, treatment generally poses a far more palatable alternative. Pursuant to Section 1548(b) of the Vehicle Code, the Court may order a pre-sentence report for "habitual offenders," and may, if deemed necessary, require commitment for treatment at an approved mental health facility.

(3) ***The Decision Not To Prosecute***

Often, the prosecutor may decide because of the special conditions of the accused, or the weakness of the evidence, or a combination of these, not to prosecute at all. Often this will

be accomplished because a concrete treatment program has been undertaken, or, is about to be undertaken.

A decision to dismiss "without prejudice" is a method of avoiding the stigma and burden of a trial in exchange for treatment which also contains some guarantee of compliance by the DUI offender. ***Failure to comply within the assigned period may result in the reinstatement of charges.***

B) ***The Role of the Deferse Attorney***

While it is clear that the short-term best-interest of any accused dictates an acquittal, we must question whether or not this possibility really helps the problem drinker, his family, or the public. Treatment can always be considered as part of a sentence. It can also result in ARD or a ***nol pros***. A well-designed treatment program presented to the prosecutor and/or the ARD judge can be persuasive in this decision-making process.

Again, the defense attorney must review all of the available information in order to make a satisfactory evaluation of the client regarding his/her problem drinking. The diagnostic evaluation presented elsewhere in this manual should be seriously considered in your decision-making process. ***Remember,*** a high BAC, 0.15% or above, indicates a potentially serious problem drinker.

Following your scrutiny of the case, an agonizing decision must be made: should the case be tried or should some form of treatment be sought prior to trial? Only a lawyer is in possession of the total facts and is able to make this decision but the factors outlined herein should be considered.

The Role of the Court

The Court's function is virtually the same irrespective of what decision the prosecutor makes. If ARD is chosen, the Court will attempt to ascertain if this is an appropriate case for such a disposition. Some factors to be considered are:

(1) The circumstances surrounding the offense;

(2) Was there an accident, property damage, or personal injury;

(3) The defendant's background, prior record and alcoholic evaluation;

(4) The treatment facilities available;

(5) The possible effect on the community if defendant is permitted to continue driving;

(6) The effect on the defendant and his family if he loses his license or is incarcerated.

These basic considerations are utilized when the Court considers post-verdict disposition but there is one real difference – a failure to comply with the treatment program set out by the Court may result in incarceration because such a failure amounts to a violation of probation. Failure to comply with pre-trial probation conditions will only result in the trial the defendant had previously foregone. The availability of this additional sanction cannot be gainsaid, even if it is seldom used.

The Court may also be called upon to pass upon the prosecutor's decision to dismiss charges if an information or indictment has been lodged prior to that decision. While this is a much more limited function, the Court will usually seek to determine if this disposition is appropriate under the circumstances of that particular case.

Creative Sentencing

Statistics concerning DUI offenders can help judges to fix more sensible sentences. For instance, over 70% of all such offenses occur on weekends (6:00 p.m. Friday until 12:00 a.m. Sunday). This would seem to dictate sentencing such offenders to spend weekends in jail because the likelihood of a subsequent offense during this period is so high. When this notion is combined with the Court's natural proclivity to avoid sentencing a family man to jail because his problems will be compounded upon release, ***it appears that a weekend prison sentence would satisfy both the community's need for safety and the problem drinker's needs to work in order to maintain his family.***

Of course, the situation described above is only illustrative but the potential for creative sentencing is only limited by our own imaginations. Work-release is another example for sentencing which attempts to balance societal and individual needs. When a complete evaluation matrix is available to the Court, the judge will be able to "tailor" each sentence to meet each case. This complete evaluation matrix should include an individual offender's: (1) driving habits (Pennsylvania Department of Transportation report); (2) drinking habits (diagnostic report); (3) mental health status (diagnostic report); (4) the BAC (police report); (5) the time of the offense (police report); and (6) previous arrest record for DUI and other alcohol-related offenses (police report). These factors and others provide the Court with the raw data out of which the most socially enduring sentence can be constructed. Of course, treatment facilities must be available if the Court's sentence is to be meaningful and helpful.

APPENDIX A

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APPENDIX B

Pennsylvania Alcohol-Highway Safety Program Law Enforcement, Counseling and Rehabilitation, County Officials, and Education Program Reference List:

All of the manuals for the Pennsylvania Alcohol-Highway Safety Program can be obtained from the Pennsylvania Department of Transportation – Highway Safety Group:

Pennsylvania Alcohol-Highway Safety Program – Law Enforcement Manual: Philadelphia; Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

Pennsylvania Alcohol-Highway Safety Program – Counseling and Rehabilitation Manual: Philadelphia; Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

Pennsylvania Alochol-Highway Safety Program – County Officials Manual: Philadelphia; Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

Pennsylvania Alcohol-Highway Safety Program – Pennsylvania DUI Safe Driving School – Instructors Guide: Philadelphia; Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

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Enforcement

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PENNSYLVANIA ALCOHOL HIGHWAY SAFETY PROGRAM

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PREFACE

This Alcohol-Law Enforcement Manual for the Commonwealth of Pennsylvania has been prepared by International Alcohol and Mental Health Associates, Inc. under the aegis of the City of Philadelphia's Coordinating Office on Drug and Alcohol Abuse Programs, Project Manager, Nicholas Piccone, Ed.D., Contract #6-3113 entitled "Curriculum and Instructors Guide for Use With Persons Arrested for Driving While Intoxicated (DWI)."

This Alcohol-Law Enforcement Manual was prepared for The Governor's Council on Drug and Alcohol Abuse, Commonwealth of Pennsylvania and the Pennsylvania Department of Transportation, in conjunction with the National Highway Traffic Safety Administration, Contract No. AL 76-10-4.

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FOREWORD

The drinking driver has been a major concern of persons involved in traffic supervision for years. This Alcohol-Law Enforcement Manual will enhance the development of skills in detecting, apprehending, and gathering evidence for prosecution of persons driving under the influence of alcohol or controlled substances (DUI).

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The Drinking Driver – An Overview

In the past 80 years the automobile has managed to gain universal acceptance as the preferred means of transportation for nearly all societies and cultures. It has also become one of the most unusual and sophisticated deadly weapons ever known to mankind. In any given year it has inflicted greater death tolls on the American public than any of the wars fought in recent times. For example, there were approximately 45,000 United States fatalities over a 10 year battle period in Viet Nam, and 52,000 highway deaths in the year of 1972 alone. The startling aspects of these highway fatalities statistics include not only the high percentage of non-driver deaths, but the fact that nearly 50% of these fatalities are considered by experts to be alcohol-related. Yet, it appears that most citizens and governmental leaders are still unaware of, or unable to respond to, the tremendous responsibility to develop innovative personal or organizational responses to this problem.

In the Commonwealth of Pennsylvania, as throughout the United States, the problem exists in various forms and, as local political practices and leadership conditions permit, countermeasures programs have become uniquely local in their responses to the drinking driver problem. In the new Motor Vehicle Code of Pennsylvania (Act 81), Driving Under the Influence of alcohol or controlled substances (DUI) is a third degree misdemeanor. On the first offense (conviction) the Department of Transportation ***must*** suspend the license for six months. If a second conviction occurs within three years, the Pennsylvania Department of Transportation ***must*** revoke the license for one year. "Habitual offenders,"defined as a driver with three convictions within a five year period, incur an automatic five year revocation. All offenders can be fined up to a maximum of $2,500.

In the process of apprehension, trial and ultimate disposition of the case, all the costs, except defense, are usually directly laid on the taxpayer. According to a study by Chicago Law Enforcement officials, the total costs of trials, jury, and prosecution expenses is estimated to be $10,000 per offender. When the costs and ultimate effects of jail and/or probation are included in the disposition process for three years, it could be safely assumed to raise that total by a substantial amount.

The costs to an offender are equally high when considering both personal and financial measures. Lawyers' fees, lost work, automobile retrieval/repair, civil suits for injuries, fines, loss of license, loss of income during incarceration, and special risk automobile insurance after the return of the operator's permit, all combine to create an extremely embarrassing financial and personal consequence of the arrest.

For the genuine "problem drinker" that exists within this drinking driver group, there is, unfortunately, usually no special program awareness of, or attention to, the unique conditions that afflict them, and they are treated "equally under the law" for their marginally controlled behavior. They may receive "special treatment" for multiple arrests if they defy the odds of a fatal accident more than once, but in most cases, they receive the usual penalties unique to the arresting municipality or area. In most cases they merely consider themselves to be personally "unlucky," and take their penalties equally with their "non-alcoholic" co-offenders with little thought or consideration to their extremely life threatening situation, and with maximum attention to the "unfairness" of their lot.

Thus, for the police, the courts, the governmental administrators, the alcohol rehabilitation workers, and the highway safety specialists, the marathon goes on and the score goes up.

But it doesn't have to be this way much longer, for the Commonwealth has now changed the rules. The keynote is revision and realization of the available evidence. The revision is in the existing laws relating to the drinking driver based on the evidence that each DUI driver is different from the other, and that options must be expanded to meet the problem, so that prevention and protection is increased for both the offender and for society.

It is a proven scientific fact that alcohol has a definite adverse effect on a person's ability to operate a motor vehicle. According to Dr. Robert F. Borkenstein, Professor of Police Administration at Indiana University, the difference in relation to the drinking drivers can be placed in the following categories:

1) Drinking drivers who are skillful drivers but whose drinking is compulsive and uncontrolled. Consequently, whenever they drink, the alcohol concentrations are generally in the high ranges, even when they drive.

2) Drinking drivers who are not compulsive drinkers but who are overly aggressive, and as a result, are not good drivers under most circumstances. Alcohol moves them from bad to worse.

3) Drinking drivers to whom neither drinking nor driving is usually a problem. They will occasionally drive when they have had too much to drink.

4) Drinking drivers who are unusually sensitive to the effect of alcohol.

5) Drinking drivers who are learners or beginners in both drinking and driving. Their experience and skill in each area is limited and therefore their driving behavior may be uncertain and unpredictable. This class includes some teenagers.

6) Drinking drivers who because of age or illness are losing or have lost their driving skills. Alcohol accentuates this loss of skill.

7) Drinking drivers who have no problem with drinking or with driving. They conscientiously and consistently manage to be below the threshold of impairment from alcohol for them when they drink and then drive.

There is steadily mounting evidence to show that drinking drivers in category one are involved in a disproportionate number of fatal crashes. With their consistently high blood alcohol concentrations when drinking and driving (evidence of problem drinking or alcoholism), they are a menace to themselves and to others.

This fact was underscored in the ***1968 Alcohol and Highway Safety Report to the United States Congress.*** That report states: "Alcoholics and other problem drinkers who constitute but a small minority of the general population account for a very large part of the overall problem."

In a report from the Advisory Committee on Traffic Safety to the Secretary of Health, Education and Welfare, it is stated that: "The overwhelming weight of evidence is that alcoholism plays a very substantial role, and probably the major role, in the occurrence of traffic accidents involving the use of alcohol."

This is what this manual is about; a new look at an old problem. We hope that you as a reader, a potential victim and a law enforcement professional will be able to use your new impressions to prevent and protect yourself, your family, and your community. Most importantly it cannot be done on a single person level or even with one agency or department. ***To respond to this problem will require a concerted, cohesive and cooperative agreement between the police, judiciary, and rehabilitation personnel, with mutual concern and trust necessary to achieve a common goal.***

The Effect of Blood Alcohol Level on Driving

Alcohol affects all the cells of the body, but the most dramatic results of ingesting alcohol occur in the nervous system, especially the brain. The central nervous system, especially the brain, is primarily affected by alcohol, with an early apparent stimulation resulting from depression of inhibitory control mechanisms. Discrimination, insight, memory, concentration, and perception are all dulled by alcohol, while speech may become eloquent, and mood swings uncontrolled. Complex behavior patterns are released that depend essentially on the personality of the individual, external stimuli from the environment, and tolerance for the drug. Alcohol seriously diminishes both mental and physical abilities, although when under its effect people overestimate their performances. For any given blood alcohol level, the effects of alcohol are more noticeable when the alcohol concentration in the blood is rising than when it is falling. High levels of alcohol affect the ability to discriminate between lights of different intensities. Narrowing of the visual field occurs and may be particularly dangerous in automobile driving. Resistance to glare is impaired so that the eye requires longer to readjust after exposure to bright lights. Sensitivity to certain colors, especially red, appears to decrease.

Although, the question of the effect of alcohol on gross behavioral change is not yet fully resolved, the results are unanimous in showing that driving skills already begin to deteriorate at blood alcohol levels below 0.05%. This level of alcohol in the blood would be reached, broadly speaking, in a person weighing 190 lbs. who had consumed three (3) 12-ounce beers or three (3) cocktails containing one ounce each of 86 proof alcohol within one hour before driving. Although other factors, such as the presence of food in the gastrointestinal tract, influence the rate of entrance of alcohol into the bloodstream, a 120-pound person would achieve a blood alcohol level of 0.05% with less than two (2) 12-ounce bottles of beer or less than two (2) cocktails containing an ounce of whiskey each.

Increasing concentration of alcohol in the blood is related to a number of driving errors, e.g., carelessness, reduced exactitude in steering and braking, more frequent stalling at critical moments, etc. 0.05% alcohol in the blood produced a tendency to drive toward a road ditch in 82% of cases

studied. With 0.10% blood levels, drivers consistently fluctuated between low and high speeds, swerved from lane to lane, and used excessive amount of time to return to the correct lane. Blood alcohol levels of 0.10% adversely affect normal driver performance by 15%, with deterioration increasing to 30% with blood alcohol levels of 0.15%.

There is no question that the probability of vehicle accidents increases sharply as the driver's blood alcohol level increases. The chance of accident involvement where blood alcohol levels are between 0.05% and 0.10%, is two to seven times greater than persons at zero BAC and at 0.15%, it is approximately 25 times greater. These estimates are given indirect support by studies which show a positive correlation between blood alcohol levels and other serious relevant variables, such as extent of damage, expense of damage, and severity of injury.

Driving Under the Influence of Alcohol or Drugs

(1) ***Unlawful Condition of the Driver***

Driving Under the Influence – There is only one driver condition that specifically requires enforcement action. It is driving under the influence of intoxicating liquor or drugs (DUI) or the combination thereof.

Difficulty of Enforcement – Enforcement agencies recognize that the drinking driver is an important contributor to accidents. A fundamental reason for difficulties in enforcement is probably the wide social acceptance of alcoholic beverages. Because most people use alcoholic beverages socially, they feel they cannot be severe with drivers who get into trouble because they drive after drinking.

Difficulties of Prosecution – Penalties following conviction for driving under the influence are severe. The driving privilege is automatically withdrawn upon conviction in Pennsylvania.

(2) ***Polydrug Use and the DUI Arrest***

The drug/alcohol combination in many instances produces a mutual aid effect whereby each enhances the effect of the other so that one plus one no longer makes two but makes four or five units of effect. This multiplying effect known as synergism explains the "cheap drunk" accomplished with a bottle of beer and a single pill or capsule of any one of several hypnotic drugs. ***Obviously, a blood alcohol determination alone would grossly underestimate the driver impairment when polydrug use is noted.***

When the signs of impairment are extensive and the blood alcohol level is low (in general below the legal limit) and thus seems inconsistent, the police officer should investigate the possibility that other drugs are involved in the suspected DUI offense.

There may be instances in which a driver exhibits abnormal behavior and clearly appears under the influence of ***something***. In such cases, it sometimes develops that he has taken some kind of drug in addition to liquor, thereby being under the "combined influence" of both liquor and drugs. Because of this combination, his condition is such that he becomes intoxicated from a lesser amount of alcohol than would ordinarily be associated with his resulting behavior. The courts have determined that such a person is nevertheless under the influence of liquor because he has lowered his susceptibility to alcohol.

(a) ***Narcotics*** (primarily opiate derivatives, heroin, morphine, etc.) – Narcotics require only very small dosages in the average person to produce diminished sensibility to such uncomfortable sensations as pain, hunger, and fatigue. They induce the pleasing sensations of emotional tranquility. Such mental functions as concentration, judgment and memory are disturbed as the subject becomes dreamy and drowsy with the exclusion of external stimuli. With this impairment, the driver fails to notice traffic signals, while speed and distance are only vaguely realized due to inattention and reduced visible accuity.

It is immaterial whether the driver is taking such drugs on his own or by prescription of a licensed physician since his driving ability is affected either way. ***Authorized use is not a defense.***

(b) ***Barbiturates and Tranquilizers*** – Barbiturates are generally prescribed by physicians to calm nervousness and induce sleep. Occasionally, the hypnotic effect is preceded by excitement and behavior best described as inebriation. The barbiturates may be grouped broadly into long-acting and short-acting based upon duration of effect. In capsule form, they have found wide illicit use and such names as "red devils," "yellow jackets," "goof balls," etc. were given street names based on capsule color. In general, barbiturates influence has the same effect as alcohol influence. Taken with alcohol, the combination results in very profound effects which are much greater than the simple arithmetic sum of the separate effects.

Tranquilizers (Valium,® Librium,® etc.) enjoy wide popularity for the relief of nervous tensions and anxieties. This group of drugs have in common a mild sedative effect without clouding consciousness or inducing sleep when taken in smaller doses. Generally, they are muscle relaxants. It is not uncommon to find individuals with high blood pressure under mild tranquilizing drugs. In large dosages or together with other drugs like alcohol, potent effects involving dizziness and drowsiness are noted amongst the DUI offenders.

(c) ***Amphetamines*** (Benzadrine® Fetamin® etc.) – These drugs in the form of tablets or capsules are used frequently by commercial drivers and others who are attempting to avoid fatigue. In general, amphetamines relieve drowsiness and fatigue created by a lack of appropriate rest and/or sleep. These drugs tend to increase mental alertness and facilitate the flow of thought, but this occurs at the expense of concentration. A "false sense" of self confidence and well being is commonly reported by amphetamine users. In its most dangerous form, amphetamine abuse by drivers stems from excessive use where sleep is postponed by days rather than hours. Traffic officers report such descriptions as "asleep with eyes open" and "little or no response to questions."

Obviously, such persons have forced themselves into a state of physical exhaustion. Like the effects of alcohol, decreased attention to the process of driving renders the drug user less capable, since his normal abilities are seriously impaired.

(d) ***Antihistamines*** – This family of synthetic drugs is used to control allergies and the attending symptomatic discomfort. They act chiefly by sedation causing inattention, confusion, and drowsiness. It is a well noted fact that this confusional state will dispose the operator of an automobile to serious highway accidents.

Allergies constitute a large proportion of medical practice and the antihistamines form a major part of that corrective regimen. Such widespread use naturally presents the danger of a driver under the effects of an antihistamine drug. These drugs are known to have erratic and unpredictable effects on many persons so that the unsuspecting driver may be caught unaware of the antihistamine effect.

(e) ***Driver Conditions Due to Physical Ailment*** – There are a number of instances in which the impaired driver is alcohol-drug free. While these conditions can be hazardous there is no specific legislation against driving while under their influence. Often these conditions, which are not the result of alcohol or drugs, produce symptoms that can be mistaken for those of alcohol influence. For example, the existence of a physical ailment does not constitute a violation of any law nor does driving while in extremely tired, angry, or overwrought condition. However, driver conditions resulting from causes other than liquor or drugs may become important elements in cases involving negligence, reckless driving, or reckless homicide. Especially if the person so affected continues to drive despite his knowledge that he may have a seizure, "blackout," etc. Such disregard of safety is commonly held to be willful or wanton because the driver shows indifference to harmful consequences which are likely to follow. In general, the arresting officer should be aware of the fact that symptoms indicative of intoxication may be the result of some other condition in the driver.

(3) ***Disorders Resembling Alcoholic Intoxication***

Diabetes – A person who is staggering and apparently drunk could be a diabetic suffering from low blood sugar - a condition that occurs in diabetics who have taken too much insulin or failed to eat enough to keep their blood sugar level normal. Also, a person suffering from diabetic coma as a result of not having enough insulin may be confused with an unconscious "drunk." A sweet odor similar to alcohol may be present - this is due to a substance called acetone which may accumulate in the blood.

Epilepsy – Epileptics may sometimes wander for hours in a confused state, some may even become violent for brief periods of time.

Head Injury – A serious possibility in the case of an apparently uninjured, apparently alcohol-influenced accident victim. Some slight bleeding under the covering of the brain may at first produce confused symptoms similar to intoxication, or unconsciousness.

High Blood Pressure – The victim of this disease in an acute state may become temporarily irrational.

Mental Conditions, Brain Tumors, Brain Abscesses, Brain Infections – These may give rise to unpredictable behavior and peculiar spells.

Stroke or Apoplexy – Both conditions are due to disturbances of blood circulation in the brain and either one can cause dizziness, confusion, vomiting or unconsciousness.

Degenerative Diseases – Various degenerative diseases of the brain and nervous system may cause a person to stagger, act silly, be forgetful or wander aimlessly.

Uremia – A form of kidney failure which causes vomiting, convulsions, and coma.

Wernike's Syndrome – A complication which may occur in alcoholism in which the victim – even when not drinking – is confused, has faulty muscular coordination, or may have paralysis of the eye muscles.

Carbon Monoxide Poisoning – This can cause dizziness, nausea, weakness, inability to walk, unconsciousness and, eventually, death. After the symptoms are well developed, the victim turns a peculiar shade of cherry red.

Elements of a DUI Arrest

The now outdated Pennsylvania Motor Vehicle Code, Section 1037, defining "Driving Under the Influence of alcohol or controlled substances" stated:

> It shall be unlawful for any person to operate a motor vehicle, tractor, streetcar, or trackless trolley omnibus, while under the influence of intoxicating liquor or any narcotic drug or habit producing drug, or permit any person who may be under the influence of intoxicating liquor or narcotic or habit producing drug, to operate any motor vehicle or tractor owned by him or in his custody or control.

In the final days of the 1976 session of the State Legislature, a new and comprehensive vehicle code was enacted. Section 3731 of Act 81 defined the offense as a ***third degree misdemeanor*** while retaining the basic definition of the former law. It also specifically describes the combination of alcohol and controlled substances capable of rendering a person unable to drive.

What Must the Arresting Officer Prove – To convict a person of driving under the influence, you must have evidence that will convince a judge and/or jury of the two elements of the offense:

(1) The suspected person was either driving, operating, or in control of the vehicle;

(2) He/she was under the influence of alcohol or controlled substances sufficient to impair his driving ability.

Detection of the Drinking Driver

It is the arresting officer's responsibility to obtain the evidence necessary to substantiate the enforcement action which he initiates. The gathering of evidence begins with the first observation of the suspect vehicle. What directed your attention to a particular vehicle, and what did the driver do to arouse suspicion as to his driving ability?

Detection of the driver who is possibly "driving while under the influence" is initiated in one of four ways:

(1) Direct observation of the individual while he is driving the vehicle.

(2) A report from some other person of the individual's driving.

(3) As a result of a call to the scene of an accident.

(4) As the result of stopping the individual for an infraction of a driving rule or as a result of a check of loads, lights, equipment, operator's license, etc.

The officer must mentally record, with accuracy, not only the normal actions which should be expected, but also the individual's abnormal or unusual actions. ***He should make written notes of all he has seen and of the statements of witnesses at the earliest practicable time so that evidence to support prosecution is properly memorialized.***

Drivers operating their vehicles in any manner which would raise doubt as to their sobriety or other abnormal condition should be stopped and the cause for the erratic driving ascertained. A few examples of deviations from normal driving, for which the officer must be alert, are listed below:

(1) Unreasonable speed where geographical characteristics or other circumstances would ordinarily compel a more moderate rate of travel.

(2) Weaving from road edge to white line; sharp, jerky movements in correcting direction of travel.

(3) Driving in spurts, first slow and then fast, or vice versa.

(4) Frequent lane changing coupled with excessive speed.

(5) Improper passing without sufficient clearance or cutting in. Taking too long or swerving too much in overtaking and passing, i.e., overcontrolling.

(6) Overshooting or disregarding traffic signs or signals.

(7) Approaching signs or signals unreasonably fast or slow, and stopping or attempting to stop with uneven motions.

(8) Driving at night without lights; delay in turning them on after starting from a parked position.

(9) Driving at night with parking lights.

(10) Unnecessary use of high beam lights and ignoring signals from other motorists to lower beams.

(11) Unnecessary use of turn indicators.

(12) Driving in lower gears without apparent reasonable cause or repeatedly meshing or clashing gears.

(13) Jerky starting or stopping.

(14) Driving unreasonably slow.

(15) Driving too close to curbs or appearing to hug the shoulder or center of the roadway, or continually straddling the center lines of other lane markings.

(16) Driving with windows rolled down in cold weather.

(17) Driving or riding with head partly or completely out of window.

In summation, once a driver is suspected of being under the influence of intoxicants, every reasonable effort should be made to stop him and remove him from the highway immediately. It is not necessary to obtain any further observations on the subject's manner of driving. To allow the suspect to proceed for this purpose could result in an accident. So a defense point conceivably could be raised on the presumption that the officer was "not sure" and was required to make a prolonged observation before stopping the defendant.

Flashing lights, sirens, whistles, and even the sight of a police vehicle can sometimes startle a sober driver. Policemen should be alert to the effect they may have on a drinking driver.

Establishing Proof of Physical Control

For a conviction, it is often only necessary for a driver to be in physical control of a vehicle. You may take enforcement action even though the car is not in motion because a potential hazard is grounds for action as well as actual hazard. There are three distinctions regarding the handling of a vehicle:

(1) Driving is controlling a vehicle's speed and direction while it is in motion.

(2) Operating is manipulating the controls of a vehicle that govern its motion.

(3) Being "in legal control" of a vehicle is a much broader term than either driving or operating it. By definition, "in legal control" is more inclusive and flexible than either the term, "driving" or "operating." All it requires is proof that the accused was in a position to regulate movement of the car, whether he/she is actually doing so or not.

Many driving under the influence cases are detected as a result of an accident. Under normal circumstances, a police officer needs a warrant in order to make a misdemeanor arrest unless the misdemeanor was committed in his view. The Pennsylvania Motor Vehicle Code (Act 81), states that a police officer may, upon probable cause without a warrant, arrest any person for driving under the influence in cases causing or contributing to an accident.

Example situations:

(1) A policeman arriving at the scene of an accident may ask those present who was operating a certain vehicle. If the operator voluntarily answers and is subsequently found to be intoxicated, you may arrest and use his/her "answer" to furnish probable cause and as substantive evidence in court. It has been held that this type of question is proper and necessary in the course of an accident investigation and does not violate the defendant's rights if asked prior to the Miranda warning, so long as no deception is involved. (Commonwealth v. Jacoby 311 A. 2d 666 (1973).

Any information received at the scene of an accident identifying who was operating the various vehicle(s) involved is enough probable cause to investigate further for a possible "driving under the influence" violator. If witnesses are used to identify the operator who is under the influence the witnesses' names must be recorded and they must be subpoenaed into court. Although hearsay evidence is inadmissable at trial it may be used to provide probable cause for arrest.

Apprehension – The gathering of evidence continues as the suspect is apprehended. The driver's response to the red light alone or to the red light and siren should be recorded as additional evidence to assist in proving or disproving, beyond a reasonable doubt, the element of "under the influence."

Some of the reactions observed during the apprehension are:

(1) An unusually fast compliance to the red light and siren or a so-called "screeching halt," either on or off the roadway.

(2) A slowness or hesitancy to comply.

(3) A seeming ignorance of the attempts made to stop the vehicle.

(4) An attempt to outrun the patrol vehicle.

(5) Over diligence in the use of arm signals as the vehicle is being stopped.

(6) An attempt to dispose of bottles or cans of alcoholic beverages by dropping or throwing them from the vehicle before it comes to a complete stop.

Proof of Impairment may be shown by two methods or a combination of them. In order to prove the second element of the offense you will have to:

(1) Produce testimony describing the suspect's appearance, actions, and condition.

(2) Conduct or initiate a chemical test that will show the amount of alcohol in the suspect's bloodstream.

Observation and Interrogation

The arresting officer holds the key to the successful prosecution of the case. The keenness with which the officer observes, the thoroughness of his interrogation and his accurate recording of evidence will give weight to his testimony.

As the officer approaches the suspect, he should mentally record and weigh each factor that could be used to prove the condition of the driver and the vehicle's occupants.

The officer should always be alert for signs of the influence of alcohol even though the subject's driving may not have indicated the probability of such influence. The following examples may be symptoms of the driver's true condition:

(1) The odor of intoxicants on the breath.

(2) Attitudes reflecting alcohol influence – signs of nervousness, cockiness, unusual cheerfulness, apparent hesitancy in complying with lawful orders or instructions.

(3) The appearance associated with that of sleep.

(4) Driver's use of his fingers while removing his operator's license from his wallet or from the transparent container in the wallet. If his fingers are swift and sure, it is a good indication that his nervous system has not been too adversely affected by alcohol. If the control of his fingers are unsure and he has difficulty in coordinating the movements necessary to remove the license, it adds much weight to the suspicion that he is under the influence of alcohol. A very thorough and complete investigation of the individual should then be made. It should be remembered that other factors may cause some fumbling, and the use of good judgment by the officer is essential.

It is imperative that the possibilities of such conditions be explored in order:

(1) To prevent the injustice of an innocent person being prosecuted.

(2) That a person who is ill or injured may not suffer further aggravation by being incarcerated.

(3) To anticipate a possible defense to the charge of intoxication.

While the presence of any of the above conditions does not negate the giving of a further and more complete examination by the officer, the subject's condition may require immediate medical attention. If this is suspected, the officer should then delay any further examination and bring the subject before a doctor competent to distinguish between the alleged condition and alcoholic influence. If the condition is found to be resulting only from alcohol, the physician is then in a position to furnish expert testimony as to the degree of intoxication and to rebut any other condition alleged. If deemed necessary, the officer may then complete the examination.

Examination

Prior to the administration of any roadside sobriety examination, it would be well for the officer to ascertain that he is not located in a potential trouble area. Although it is recognized that ***any*** area can be a potential trouble zone, it is generally agreed that certain places rank high on the list as being imminently dangerous. To point out a few:

(1) In front of a tavern.

(2) In front of a person's residence, with a gathering of people consisting of his ill-tempered family.

(3) In an area which has a history of being a source of racial strife and rioting.

(4) Within sight of any large gathering of people.

In the event that such a situation should present itself, the suspect should be removed from the scene as quickly as possible, and the examination conducted elsewhere. If the suspect proves himself not to be under the influence of alcohol, he should be returned to the location where apprehended and released.

Examination by Officer – The officer should determine the suspect's ability to coordinate his faculties at the location where he is apprehended. He should supplement his general observations by noting specific actions, such as ability to walk, ability to stand, speech, odor of breath, tremor of hands, condition of hair, condition of eyes, color of face, marks or injuries, general appearance, and unusual acts, keeping in mind that symptoms of intoxication are not always the result of the consumption of alcohol.

Specific questions are asked and general coordination is measured by observing the ability to perform ***simple*** tests. It should be emphasized here that the tests should not be so complicated or difficult that the average person could not perform them when not drinking. The officer must bear in mind that the jurors will probably attempt the tests in the jury room during deliberation of a case. The answers to questions, the results of tests, and other observations are recorded on the "Intoxication Report."

Each coordination test should be explained and demonstrated to the subject in such a manner that he understands just what is expected of him.

If possible, have a citizen witness, or another police officer witness the coordination tests that are given. The impartial witness could testify not only to the performance of the tests, but to the fairness of the officer as well.

Coordination Tests – The following tests are standard coordination tests. These are the only tests which may be given, excepting as otherwise directed by the local district attorney. Test 1, 2, 3, 4, and 5 require a smooth, level surface upon which to stand.

1. Finger to nose.

   a. Subject stands erect with feet together, eyes closed, and arms outstretched. Alternating left hand and right hand, under direction of the officer, the subject swings his forearm in from the elbow, attempting to touch the tip of his nose with the tip of his extended finger. (Illustration #1).

   b. Test is ability to coordinate movements to accomplish touching tip of nose with finger tips, retain balance, and follow simple directions.

2. Modified Position of Attention

   a. Subject stands at "attention" position, heels and toes together, eyes closed, head tilted back slightly. (Illustration #2).

   b. Test is ability to retain balance. Observe and record sway and/or loss of position.

3. Heel/Toe

   a. Subject is directed to walk a straight line placing one foot before the other in a heel against toe position. (Illustration #3).

   b. Test is ability to retain balance, place heel against toe, and maintain a straight course.

4. Walking a line.

   a. Subject is directed to walk to a specified object, turn and return.

   b. Test is ability to retain balance, maintain a straight course, and turn smoothly.

5. Standing on Line

   a. Subject is directed to stand in a heel to toe position. (Illustration #3)

   b. Test is ability to retain balance.

6. Pronunciation

   a. Subject repeats the alphabet. An inquiry should be made to ascertain the subject's educational level if he has difficulty with the test.

7. Dexterity

   a. Have subject count on fingers. He touches his first finger to his thumb and counts "one", then middle finger to thumb and counts "two," third finger and counts "three," and little finger and counts "four." The order is then reversed; 4, 3, 2 and 1.

b. Test is ability to coordinate finger movements and speech.

c. Have subject pat back of right fingers into palm of left hand, then turn right hand over and pat front of fingers into palm. This test should be performed several times in a relatively rapid manner.

d. Test is ability to coordinate hand movements.

e. Place coins or similar objects on hood of car in front of subject within reaching distance; have subject reach out, pick up object and place in officer's hand.

f. Test is degree of deviation from ability of sober person to accomplish same act.

8. Standing on one foot

a. Subject is directed to stand on one foot for a specified period of time.

b. Test is the ability to retain balance.

Examination by Doctor – Special examinations are made by police surgeons or qualified physicians. These generally include the coordination tests given by the officer and, in addition, a general clinical examination for the purpose of distinguishing genuine illness from intoxication. The physician usually prepares a certificate stating the results of the various tests and certifying whether or not the person is under the influence of alcohol.

The doctor's opinion is based on his medical training and knowledge and the observed condition of the suspect and does not consider the officer's observation of the suspect's driving.

The results of a doctor's examination of a suspect, the laboratory anaylsis of blood, breath, urine and other body fluids are all means of determining the suspect's physical condition. They tend to corroborate the officer's charge.

Prosecution should be founded upon as broad a base of evidence as is possible. It is recognized, however, for various reasons the suspect either may not or cannot supply much information through physical testing by the officer. In these cases, it may be necessary to rely wholly upon a physician's statement or chemical test results or both.

Chemical Testing for Intoxication

Chemical analysis of human body fluids and tissues for determining the presence of alcohol has been used for many years.

The primary use of chemical analysis is to verify through its use the observations, examinations and tests performed upon a subject arrested for DUI by the arresting officer. In addition to confirming the officer's opinion, the results also give rise to certain statutory presumption.

Chemical tests can be divided into two categories: those permitting an immediate analysis, as in tests of exhaled breath and those requiring a subsequent laboratory analysis. Laboratory analysis usually is concerned with specimens of blood and urine.

By determining the amount of alcohol in the bloodstream, the degree of psychophysical impairment can be identified based on the results of national and international research. This determination of blood alcohol concentration (BAC) is stated in terms of a decimal percentage (e.g., 0.10%, 0.05%, etc.) with reference to a measurement of the weight (grams) of alcohol in a volume (100 milliliters) of blood (e.g., 0.07% g/100 ml. = 0.07%; 0.23 g/100 ml. = 0.23%, etc.)

The Pennsylvania Uniform Vehicle Code (1976 Rev.) the legal presumptions based on chemical tests are given as follows:

0.10% or more – Alcohol concentration in the body of one tenth of one percent (0.10%) or more, is ***prima facie*** evidence of being under the influence of alcohol.

0.05%-0.10% – With concentration between 0.05% and 0.10% there is no presumption either way but will be considered in conjunction with other evidence substantiating alcohol influence.

0.05% or less – Alcohol concentration in the body of five one hundredths of one percent (0.05%) or less, is presumptive evidence of ***NOT*** being under the influence alcohol.

In 1966, in ***Schmerber v. California***, the United States Supreme Court ruled that administering a chemical test for intoxication did not violate the constitutional right against self-incrimination. It is considered to be physical evidence, as are fingerprints.

Types of Chemical Testing Equipment

Breath Test – Breath testing devices are available in two forms, the first is for preliminary screening and the second for quantitative analysis.

The purpose of a preliminary testing unit is to make an immediate determination of the presence of alcohol. (***Note:*** presently this type of testing is not valid in Pennslyvania.)

Quantitative analysis devices are employed by most law enforcement departments throughout the Commonwealth.

The following breath testing equipment has been authorized by the Pennsylvania Secretary of Transportation, identified by brand names, to be used by a police officer or physician qualified to use such equipment.

The equipment is divided into two groups:

(1) "A" Type Equipment

- (a) Albreath-Model 100
- (b) Alco Analyzer (Gas Chromatograph)
- (c) Alcometer
- (d) Alcometer-Model D-1
- (e) Breathalyzer-Models 800, 900, 900a, 1000
- (f) Drunkometer

(g) Photoelectric Intoxilyzer

(h) Omicron Intoximeter

(i) Mark IV (Gas Chromatograph Intoxilyzer)

When using any of the above equipment, the operator makes a determination of the alcohol content of the blood of the person being tested.

(2) "B" Type Equipment

(a) Forrester Intoximeter

(b) Mobat Sober-Meter-Model II

(c) The DPC Intoximeter

Police departments utilizing "B" Type Equipment must retain the services of a chemist who can qualify as an expert witness for introduction of such evidence in a court of law.

Blood Tests – The blood test involved the collection of a sample of venous blood by medical personnel and analysis of the same by a qualified laboratory, using the process of distillation and titration and/or gas chromatography for the purpose of determining the amount of alcohol and/or the presence of barbiturates or tranquilizers. (***Note:*** only barbiturates and tranquilizers are detectable in a blood test. Other types of drugs are only detected by a urine test.)

Despite some of the major disadvantages (cost time factor between test and results, etc.) of the blood tests, there are times when the blood test becomes the most appropriate test. For example, if the subject has been involved in an accident and is in the hospital receiving medical attention; or in a more obvious case, if the subject is dead, in which case a breath test would be impossible. Also a blood test would be advantageous in court if the subject has a severe case of emphysema, a mouth deformity or if there's an indication of a combination of barbiturates or tranquilizers in addition to alcohol. (***Note:*** if the subject for any reason cannot supply enough air to complete the breath test, a blood test should then be offered.)

Urine Test – The urine test requires a collection of a sample of the subject's urine, by the police officer. The analysis method for the urine test is the same as the blood test. ***For alcohol determination, the urine test is the least accurate of the three available tests.***

Criteria for the Selection of an Appropriate Chemical Test – If any of the criteria for the first choice cannot be met, then the second or subsequent choice should be considered in order.

Breath Test

1. Breath test is available.

1st Choice

2. Drugs are not a major consideration.
3. Subject does not request a test other than breath.
4. There are no medical reasons prohibiting a breath test.

Blood Test

1. Subject does not refuse to submit to blood test.

2nd Choice

2. Blood test is readily available.
3. Barbiturates or tranquilizers are the major consideration.

Urine Test

3rd Choice

1. Urine test is readily available.

Requests for and Refusals of Chemical Tests – When an arresting officer has made the decision to arrest under a DUI charge, the law requires that the subject be advised of his rights concerning chemical testing.

The Motor Vehicle Code, under Implied Consent, states that a police officer has to request the subject to take a chemical test for determining the alcoholic content of his blood. The language in the statue is quite clear and there is nothing in the statue that requires you to further than request the subject to submit to the test. This was upheld in:

Commonwealth v. Abraham 300 A. 2d 831 (1973).

Commonwealth v. Schaeffer Supreme Court of Pennsylvania 1973.
You only need to ask him one (1) time if he/she consents.

Morris Motor Vehicle Operator License Case 218 Pa. Superior Court 347, 280 A. 2d 658 (1971).

Please Note: In ***Commonwealth v. Randy Guarino*** #1434, C.D. 1974 – If an offender stands mute to the question of submitting to a breath test, the police officer must take the offender to the instrument (breathalyzer) and ask the offender to submit to the test again, if he/she doesn't answer then it is considered a refusal. ***Remember, the police officer must take the offender to the breathalyzer to constitute a "mute" refusal.***

Because it is important that the chemical reflect as nearly as possible the BAC of the driver at the time he/she was actually driving, it is important that the suspect be tested shortly after the arrest is initiated. Any unnecessary delays caused by the subject would be considered a refusal. If the subject does not answer your request to take the test, this is considered a refusal. Since the penalty

for refusing a chemical test is civil (first offense, suspension of operator's license for six months), the subject does not have to be given the Miranda Warning prior to asking for his/her consent. The subject has no right to counsel before deciding that he/she will or will not take the test.

Commonwealth v. Rutan Superior Court of Pennsylvania 323 A. 2d 730 (1974). It is good police practice for the officer to inform the subject that his refusal to take the test might result in a suspension of his/her license. Under the Rutan Case, the court did say, "To secure the best evidence of guilt, police officers should act as to encourage drivers to submit to testing."

Implied consent allows for the suspect to refuse to submit to a chemical test. Under such circumstances, the arresting officer is required to complete the Officer's Sworn Report of Refusal to Submit to Chemical Test. This form is sent to: The Department of Revenue, Bureau of Traffic Safety, Control Section, 3rd Floor, Highway & Safety Building, Harrisburg, Pennsylvania 171123. (See sample Page 20)

Rights of the Suspect

The Pennsylvania Constitution, as does the United States Constitution, guarantees certain rights of its citizens. Pennsylvania rules of evidence have been promulgated to prevent an infringement upon these rights. The enforcement officer must secure and present evidence in support of the criminal charge of Driving Under the Influence of Intoxicating Liquor or Drugs in a manner conforming to these established rules and procedures.

Generally speaking, a person arrested for Driving Under the Influence of Intoxicating Liquor or Drugs has the same "rights" under the Constitution as a person arrested for any other reason.

Claims have been made that taking of blood, breath, or urine samples violate certain rights guaranteed by the Constitution.

In regard to chemical tests for the presence of alcohol in the body, the United States Supreme Court has considered the issues of self-incrimination, right to counsel, basic due process, and search and seizure. The United States Supreme Court comments on these issues in the case of ***Schmerber v. California***, 384US757 (1966).

The Schmerber case established the reliability and constitutionality of chemical testing for determining alcoholic influence. This case also establishes that a person who has been arrested for Driving Under the Influence of Intoxicating Liquor or Drugs may lawfully be required to give a sample of his blood or breath and the test results may be used against him.

The Supreme Court recognizes the difference between physical evidence and testimonial matters and clearly establishes this difference in the Schmerber case in comparing it with ***Miranda v. Arizona***, 86SCt. 1602.

Although urine is not mentioned in the Schmerber case, it can be assumed that the Supreme Court would hold that an arrested person would be under the same legal compulsion to provide a sample or urine under like circumstances.

MTR-712 (10-69)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF REVENUE
BUREAU OF TRAFFIC SAFETY
HARRISBURG
17123

IN YOUR REPLY PLEASE REFER TO

REPORT OF REFUSAL TO SUBMIT TO CHEMICAL TEST OF BREATH TO DETERMINE INTOXICATION

Name _____ Date of Birth _____

Address _____ Operator's No. _____

City _____ County _____ State _____

Date of Refusal _____

VIOLATION OF SECTION 624.1 OF "THE VEHICLE CODE" (ACT OF APRIL 29, 1959, P.L. 58, AS AMENDED, 75 P.S. 624.1)

Section 624.1 (a), in part, reads as follows: "Any person who operates a motor vehicle or tractor in this Commonwealth shall be deemed to have given his consent to a chemical test of his breath, for the purpose of determining the alcohol content of his blood: Provided, that the test be administered by qualified personnel and with equipment approved by the Secretary at the direction of a police officer having reasonable grounds to believe the person to have been driving while under the influence of intoxicating liquor".

I, the undersigned, hereby certify that the above-named person, after his arrest for violation of Section 1037 of "The Vehicle Code", and being so charged, refused to submit to a test of his breath as as provided in Section 624.1 (a), supra.

Magistrate's SEAL

_____
Magistrate
(Jurisdiction)

_____
Arresting Officer
(Jurisdiction)

Note: Address all correspondence to:

DEPARTMENT OF REVENUE
BUREAU OF TRAFFIC SAFETY
CONTROL SECTION
3RD FLOOR, HIGHWAY & SAFETY BUILDING
HARRISBURG, PENNSYLVANIA 17123

RBP-A-13

The Officer in Court

It is unlikely that the average officer will be sufficiently informed regarding alcohol and its effects to be qualified as an expert and allowed to express an opinion as such. He is, however, adequately prepared through experience and training, to describe the outward manifestations of alcoholic influence, regarding it as a matter of common knowledge to him.

He should be prepared to relate all the facts, of which he is aware, surrounding the particular case. Generally, his testimony will be carefully brought out by the prosecuting attorney who will establish the facts in the proper manner and sequence. This testimony should be directed to the jury or if the trial court is being conducted by the judge, then to him.

The primary task of the jury, in every case, is to evaluate and give weight to the testimony of each witness and from the evidence produced at the trial to decide and declare via their verdict what they believe the actual facts to be. The officer's testimony, then, should reflect the factual attitudes of the one man fact-finding bureau that he is. This should result in his testimony being given a maximum amount of credence; however, the officer should be keenly aware that the factual information alone is not decisive.

The weight given by the jury to the testimony of the officer can be influenced by many things, such as his appearance, manner, directness, reasonableness and decorum. The officer should not only possess, but should outwardly reflect a fair and impartial attitude. He should not "stretch" the facts to make his case look good. This has probably lost more cases than any other one thing. It is far better and less damaging to state a fact favorable to the defendant than to evade or give the appearance of evading a question. A clear, concise, fair, and factual recital by an officer, done in a manner insuring the belief in the existence of these qualities, cannot help but favorably impress the jury.

It must not be forgotten that most people at one time or another imbibe some alcoholic beverage. The jury may have firm convictions of their own regarding drinking and driving, together with the effect of alcohol on the human system. Those jurymen who partake of alcohol will very probably be recalling experiences of their own with liquor and in effect will each be "trying" himself as the trial proceeds.

The words fair, factual, and impartial will then be of intense interest to him. The officer, therefore, should exercise extreme caution to demonstrate through his testimony that he is not "trying" society's indulgence in alcohol, but rather, is offering testimony in the trial of the defendant.

There often is a considerable time lapse between the arrest and the trying of the case. These delays are necessitated for varying reasons:

(1) Heavy court calendars.

(2) Defendant's right to seek witnesses and evidence in his own defense.

(3) Defense counsel's availability to represent his client at the trial.

(4) Illness of any party whose testimony is essential to the case, and many other reasons.

It is recommended that the arresting officer confer with the prosecuting attorney prior to the commencement of the trial. The officer may be able to furnish added information which might have been mistakenly omitted from the intoxication report. The pre-trial conference affords both the prosecution and the officer the opportunity to familiarize themselves with the facts of the case and to discuss the scope of testimony to be delivered by the officer.

On the day of the trial some officers attempt to engage the defendant in casual conversation. Their purpose in this is to note the defendant's eyes, breath, manner of speech, coordination, and general physical appearance. These observations prove valuable for a comparison of the subject's mannerisms when under the influence and when sober. These comparisons can then be elicited in the officer's testimony.

The following questions are most frequently asked the officer in direct examination:

(1) Name and occupation?

(2) Were you so employed on date of offense?

(3) On that date did you have occasion to see the defendant in this case?

(4) What time of day or night did you see the defendant?

(5) In what locality did you see the defendant?

(6) Where were you when you first observed the defendant?

(7) What type of vehicle were you in? Who was driving?

(8) Was the defendant in a motor vehicle?

(9) What type of vehicle?

(10) Who was driving the vehicle?

(11) Who saw the defendant driving?

(12) How far from the defendant's vehicle were you?

(13) What, if anything, unusual did you see the defendant do?

(14) At what speed was he driving?

(15) How wide was the road?

(16) How many lanes of traffic does that have?

(17) Describe the manner of defendant's driving.

(18) What was the condition of traffic at that time?

(19) What, if anything, did you do then? (Here you will describe the manner in which you stopped the defendant's vehicle – what you first asked the defendant to do – any odor of alcoholic beverages or other symptoms of intoxication which caused you to have the defendant submit to sobriety examination.)

(20) Was anyone else in the defendant's car? If so, be prepared to testify concerning any statements made by that passenger should he be called as a witness for the defendant.

NOTE: At the time of arrest, if the defendant is accompanied by a passenger, the arresting officer should attempt to interrogate the passenger out of the defendant's hearing. Pertinent questions should be asked concerning the events prior to the apprehension; time of day he met defendant, where they had been, with whom, and what they had been drinking.

(21) Did you have occasion at that time to administer any roadside coordination tests to the defendant?

(22) Was the area level where the tests were given?

(23) What tests did you give?

(24) Did you demonstrate the tests to the defendant prior to asking him to perform them himself?

(25) For what were you testing when giving each test? (Finger to nose checks upper extremity coordination; balance test checks the coordination of the larger joints, etc. You will here be asked to demonstrate the tests as you describe them to the defendant and then demonstrate the manner in which the defendant performed each of them.)

(26) How many times did you give each test? If more than once, give reasons.

(27) Did you give other tests?

(28) Have you seen persons drinking?

(29) Have you seen persons under the influence of alcoholic beverage?

(30) In exceptional cases, you will be asked also whether or not you have seen a person who was under the influence of alcohol.

(31) Did you have occasion to form an opinion as to whether or not the defendant was under the influence at the time of arrest? (Do not underplay your opinion. This is primarily what will convict or acquit the defendant. Even if a person has a high blood alcohol concentration, the jury will generally not convict where the officer is not positive or is not conclusive in his opinion as to intoxication.)

(32) What is that opinion?

(33) What did you do then? (Generally, you will describe arresting the defendant, transporting him to jail, and where applicable, the drawing or refusal by the subject to submit a sample of blood.)

(34) You will be asked questions concerning completion of the intoxication report. These statements are extremely important at trial for purposes of contradicting any of the defendant's alibis. Remember that while the defendant is on the witness stand, he generally is a "clean-cut, average citizen" and the natural sympathies of the jury are in his favor. Many jurors imbibe of alcoholic beverages and may have at sometime driven in a similar intoxicated condition. It is, therefore, up to the officer and the district attorney to be able to show the jury that this person is at least a prevaricator. Oftentimes, jurors have said that they have convicted a particular defendant primarily because the people were able to convince the jury that the defendant had not told the truth while on the stand even though the evidence as to his intoxication was no more preponderant than in any other case.

(35) Have you had occasion to see the defendant since the time of arrest? (Your answer will be, "Yes, in court this morning. I approached him and had a short conversation with him.")

(36) At that time did you have occasion to notice the defendant's eyes, breath, manner of speech, color of face, manner of walking and those other symptoms of intoxication to which you had previously testified?

(37) What differences, if any, were there between the color of his eyes this morning and the color of his eyes at the time of arrest? (The same type of questions will be asked regarding breath, manner of speech, etc.)

The above does not contain every possible question the officer may be asked on direct examination.

On cross examination, the officer should be prepared to answer questions designed to test his memory of the events at the time of arrest, which may have little, if anything, to do with the guilt or innocence of the defendant. He should be prepared to give distances traveled, names of streets crossed, location of traffic controls, the exact manner of performance of each sobriety test and words spoken to him by the defendant in answer to any questions. Judges will rarely cut off a defense attorney and prevent him from asking questions which are solely designed to test the officer's memory. He should not attempt to answer questions exactly when he is not sure that he is correct. The best answer to a memory-testing question is, "I am not certain of my answer since my observations were primarily directed toward apprehending the defendant. . . ."

Current Treatment for DUI Offenders in the Commonwealth of Pennsylvania

So far as is known, there are few organized and coordinated systematic treatment programs for DUI offenders in Pennsylvania. In the City of Philadelphia, as a result of some basic research and experience, a need was demonstrated for a treatment program specially designed for problem drinkers in this population, and in 1976 four such special treatment programs are in existence. Also, in Reading, a need for treatment services was recognized, but because of the relatively small number of offenders, their objectives were accomplished within the structure of existing alcoholism treatment programs. In both these cities, the identification and evaluation of the DUI population has resulted in very substantial increases in the referral and admission of alcoholic persons to these alcoholism facilities. In most of Pennsylvania however, there is not only a paucity of alcoholism treatment services in general, but a critical shortage of services for specific groups of alcoholic patients, such as alcoholic DUI offenders.

Throughout the Commonwealth there is a limited number of Alcohol Highway Safety Countermeasures Programs, but the existing programs are, in nearly all cases, essentially educational in nature and do not emphasize, nor conduct, specific treatment on a formal basis. If treatment is mentioned at all, it is within the context of a group experience and it is invariably simply a referral or suggestion to attend an Alcoholics Anonymous open meeting, which for most DUI offenders who are earlier stage problem drinkers, may be an inappropriate modality. This is partly because of the anonymity required within the organization itself, which, by organizational philosophy, prohibits developing an accurate recording and reporting between Alcoholics Anonymous groups and the criminal justice system.

Another problem is that most existing alcoholism treatment systems emphasize inpatient treatment, which does not seem to be the most appropriate environment for the vast majority of the alcoholic DUI offenders. The experience of pilot and developing programs strongly supports the notion that these persons require outpatient approaches that are specially tailored to their needs. Treatment programs for these persons will have to relate to the special conditions of this group that reflect their special characteristics and needs.

Current research with the DUI population suggests that these persons are, generally speaking, less alcohol-impaired than the type of patient usually seen in alcoholism treatment programs. They are typically male, more often married and living with their spouses, more likely to have good employment records with continous employment, and have shorter histories of problem drinking than customarily seen in generally voluntary admissions to alcoholism treatment. Although these characteristics would suggest a better prognosis, they are counterbalanced by a significantly poorer motivation to attend and commit oneself to an enduring treatment plan. It is, therefore, very important that a treatment program become mandatory and that the full support of the criminal justice and probation systems be mobilized to ensure offender participation in treatment.

The results of a pilot demonstration program for alcoholic DUI offenders conducted in Philadelphia in 1975, suggested that, for meaningful behavior changes to occur, once weekly treatment for six months is the minimum involvement, and it would probably be more desirable to insist on

approximately one year of weekly therapy sessions to more fully implement significant, long-lasting behavior change.

There is also a critical need to provide appropriate training for Alcoholism Treatment personnel who are to be involved with the alcoholic DUI offender. They must be made fully aware of the total system in which they are to operate. This means that at least part of their training should occur in association with staff of other components of the Pennsylvania Alcohol-Highway Safety Program. This includes police, probation officers, judges, educators, and administrative officials who each contribute to a comprehensive program of this nature. There are significant differences in the treatment approaches that one might have to adopt for the alcoholic DUI offender than with other kinds of alcoholic populations. The relatively early stages of alcoholism that are characteristic of this group imply that the "rock bottom" approach may not only be inappropriate, but also counter-therapeutic, in the sense that one may be introducing a damaging self-fulfilling prophesy. It has been unfortunately the case in our culture that most alcoholic patients have not entered treatment until there has been significant social and physical deterioration. Therefore, the traditional approaches which might apply to this latter category of alcoholic patient might not be indicated or necessary for these persons arrested for DUI. This implication must be included in any training program where an approach based on the availability of multiple treatment modalities, used in flexible combinations, should be emphasized.

Any treatment program for alcoholic DUI offenders should be seen as an integral part of a total system, under the control and leadership of a single local coordinating authority. The treatment system must link with, and provide continuity of care from the judicial, probation and parole, and educational components, and should also be closely allied to existing alcohol and general health care delivery systems. There are many different ways in which this could be accomplished, and in each community the DUI treatment system should become part of the local health care delivery system with special ties to both Drug and Alcohol, and Mental Health Programs. The vitally important part played by the local criminal justice system, which will include police, judges, prosecutors, defenders, and probation and parole officers cannot be overemphasized. ***It is strongly recommended that a specific training program involving all these multidisciplinary components should be organized by any community interested in developing an alcohol-highway safety countermeasures program, and should occur at the earliest possible stage of program development.***

Past, Present, and Future Directions for DUI Countermeasures

Over the past 80 years of driving legislation, there have been few attempts to legislate drinking driving prevention into the Motor Vehicle Code of Pennsylvania.

The Federal Government and the United States Department of Transportation have for many years studied the problem of Driving Under the Influence, and after the preparation of a special report to Congress in 1968, made several significant recommendations designed to improve prevention in this area. These recommendations were included in the model traffic code known as

the Uniform Motor Vehicle Code which has served as the base for the newly enacted Pennsylvania Motor Vehicle Code of 1976, which significantly updates the law in nearly all aspects of traffic safety.

It is now apparent that a more balanced approach to the problem will be adopted, with the recognition that the criminal justice system and the treatment and rehabilitation systems must become partners in any meaningful efforts to reduce the effects of this major public health problem.

Some technological developments are sure to have a marked effect on alcohol-highway safety detection and rehabilitation in the coming decade. Portable pre-arrest screening devices are already perfected for police patrol and when such easily utilized instruments are in the hands of law enforcement officers, a major obstacle to initial identification of the drinking driver will be overcome. The increased organization and standardization of DUI countermeasures in Pennsylvania is sure to have a marked effect on the development of improved administrative and clinical procedures in the management of the problem. Some possible approaches in treatment would include mandatory disulfiram therapy for repeat or resistant offenders, increased use of weekend or evening incarceration, and extensive use of Accelerated Rehabilitative Disposition (A.R.D.). Also, the use of sophisticated breath analysis techniques should be encouraged in all programs involved in evaluation, treatment, and rehabilitation of selected DUI offenders. Such technology will help to refine diagnosis, and objectify and standardize alcohol abuse behaviors. This will facilitate clear communication, and therefore foster relationships between rehabilitation staff and the DUI offender. Technology advances are especially important in the use of accurate and understandable measures of condition and progress shared by the therapist with the client.

Of great significance is the growing emphasis on the quality of alcoholic treatment facilities themselves. Standards for operation and licensing as well as national accreditation for alcoholism treatment programs are now a reality. It is also apparent that this process will accelerate the demise of many marginal and ineffective programs and encourage high administrative and clinical standards for the surviving few. Any form of national health insurance is sure to be linked to the most advanced treatment systems, and payment for any such services will certainly be associated with accredited programs with strong outpatient and aftercare elements.

Program Interrelationships

While there are clearly differences in programs operating within the various communities in the Commonwealth, it is apparent that some basic elements must always exist in order to conduct any effective countermeasures program; simply stated, they are law enforcement, judiciary, and rehabilitation. The following flowchart is provided to give a graphic illustration of a fully functioning and comprehensive countermeasures program in the Commonwealth of Pennsylvania.

PENNSYLVANIA ALCOHOL-HIGHWAY SAFETY PROGRAM (PAHSP)

FLOWCHART

I. LAW ENFORCEMENT SECTOR

IA. Arrest Process

II. JUDICIAL SECTOR

IIA. District Attorney Pre-Trial Screening

IIB. Trial Proceedings

IIC. Post-Diagnostic Court Ruling

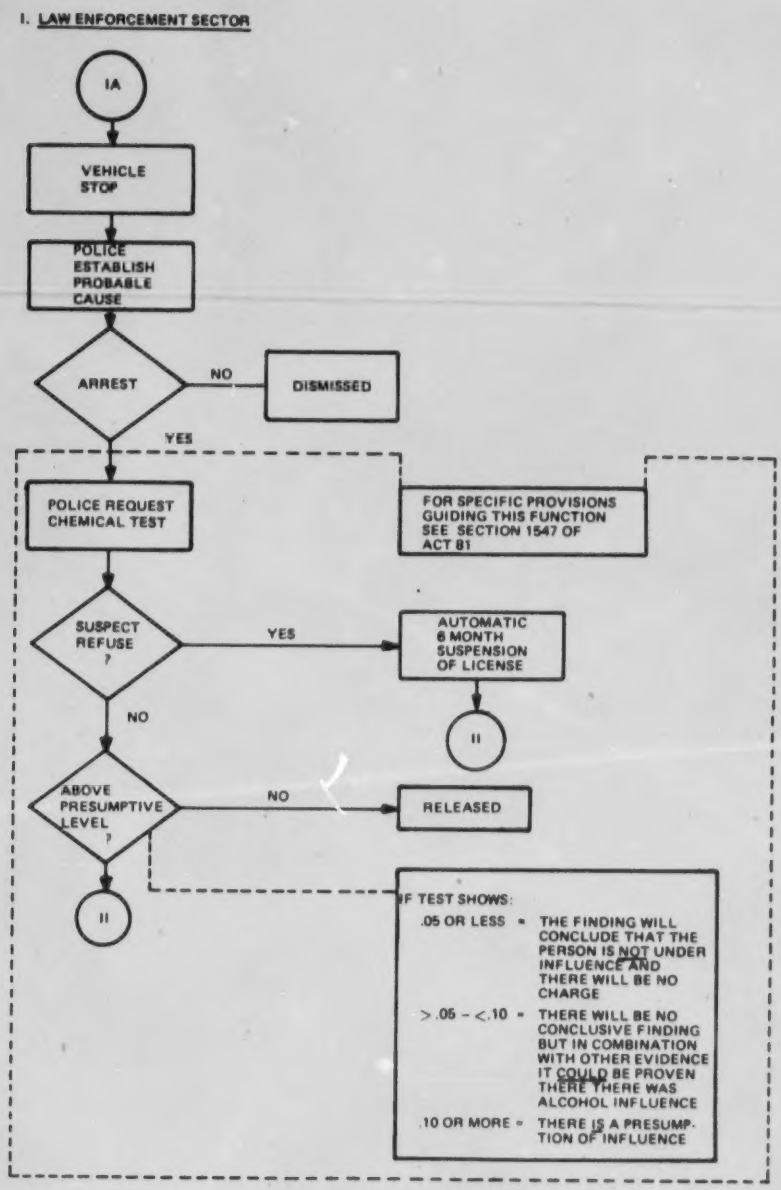
III. REHABILITATION SECTOR

IIIA. Diagnostic Evaluation

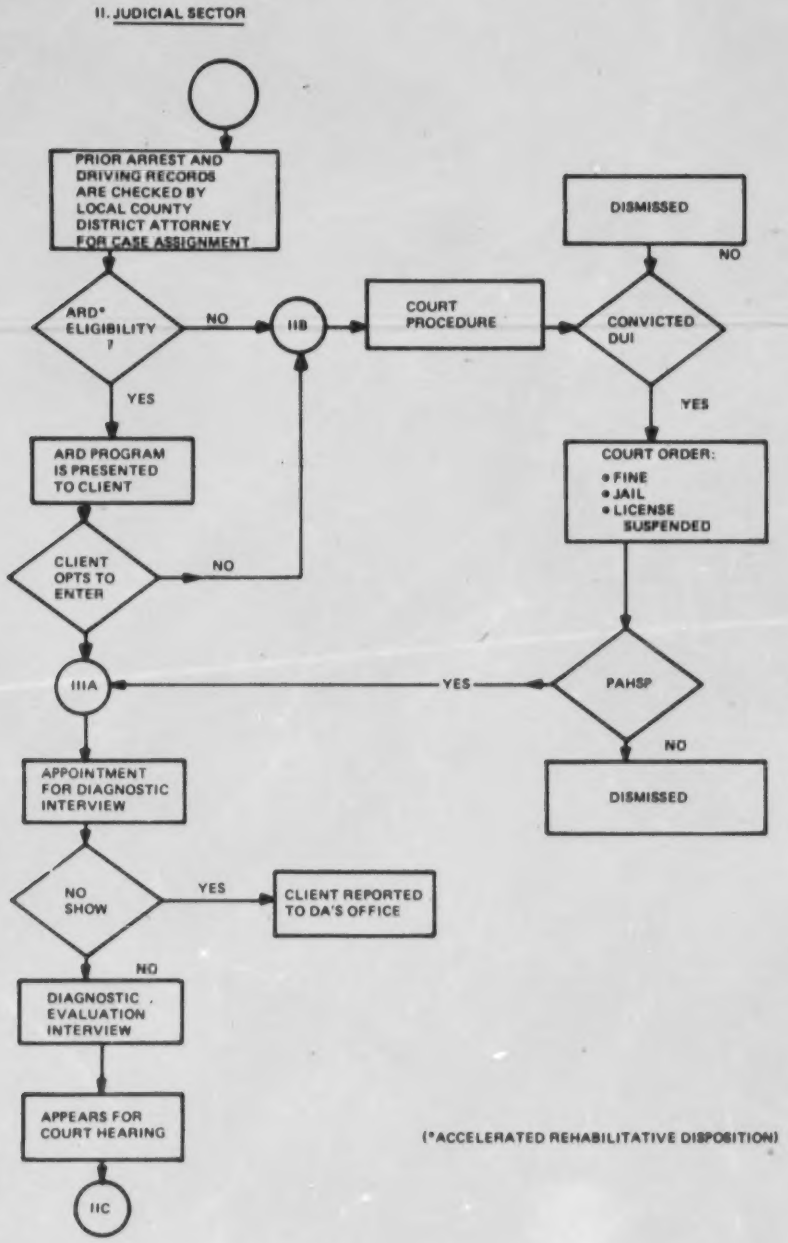
IIIB. Psycho-Medical Treatment

IIIC. PAHSP Safe Driving School

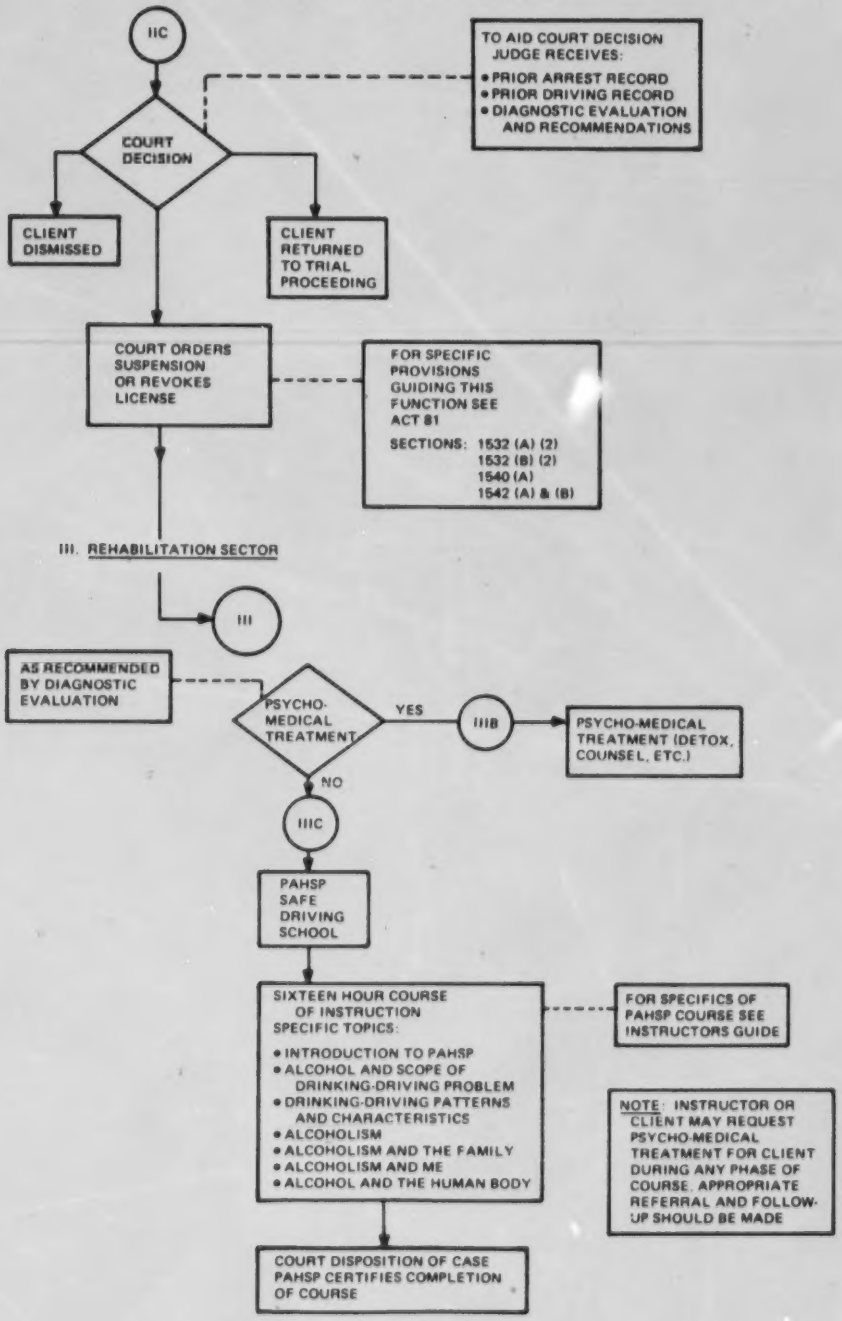
PAHSP – FLOWCHART (1)


I. LAW ENFORCEMENT SECTOR
IA
VEHICLE STOP
POLICE ESTABLISH PROBABLE CAUSE
ARREST
NO
DISMISSED
YES
POLICE REQUEST CHEMICAL TEST
FOR SPECIFIC PROVISIONS GUIDING THIS FUNCTION SEE SECTION 1547 OF ACT 81
SUSPECT REFUSE ?
YES
AUTOMATIC 6 MONTH SUSPENSION OF LICENSE
II
NO
ABOVE PRESUMPTIVE LEVEL ?
NO
RELEASED
II
IF TEST SHOWS:
.05 OR LESS = THE FINDING WILL CONCLUDE THAT THE PERSON IS NOT UNDER INFLUENCE AND THERE WILL BE NO CHARGE
>.05 - <.10 = THERE WILL BE NO CONCLUSIVE FINDING BUT IN COMBINATION WITH OTHER EVIDENCE IT COULD BE PROVEN THERE THERE WAS ALCOHOL INFLUENCE
.10 OR MORE = THERE IS A PRESUMPTION OF INFLUENCE

PAHSP – FLOWCHART (2)



PAHSP – FLOWCHART (3)


IIC
TO AID COURT DECISION JUDGE RECEIVES:
• PRIOR ARREST RECORD
• PRIOR DRIVING RECORD
• DIAGNOSTIC EVALUATION AND RECOMMENDATIONS
COURT DECISION
CLIENT DISMISSED
CLIENT RETURNED TO TRIAL PROCEEDING
COURT ORDERS SUSPENSION OR REVOKES LICENSE
FOR SPECIFIC PROVISIONS GUIDING THIS FUNCTION SEE ACT 81
SECTIONS: 1532 (A) (2)
1532 (B) (2)
1540 (A)
1542 (A) & (B)
III. REHABILITATION SECTOR
III
AS RECOMMENDED BY DIAGNOSTIC EVALUATION
PSYCHO-MEDICAL TREATMENT
YES
IIIB
PSYCHO-MEDICAL TREATMENT (DETOX, COUNSEL, ETC.)
NO
IIIC
PAHSP SAFE DRIVING SCHOOL
SIXTEEN HOUR COURSE OF INSTRUCTION
SPECIFIC TOPICS:
• INTRODUCTION TO PAHSP
• ALCOHOL AND SCOPE OF DRINKING-DRIVING PROBLEM
• DRINKING-DRIVING PATTERNS AND CHARACTERISTICS
• ALCOHOLISM
• ALCOHOLISM AND THE FAMILY
• ALCOHOLISM AND ME
• ALCOHOL AND THE HUMAN BODY
FOR SPECIFICS OF PAHSP COURSE SEE INSTRUCTORS GUIDE
NOTE: INSTRUCTOR OR CLIENT MAY REQUEST PSYCHO-MEDICAL TREATMENT FOR CLIENT DURING ANY PHASE OF COURSE. APPROPRIATE REFERRAL AND FOLLOW-UP SHOULD BE MADE
COURT DISPOSITION OF CASE PAHSP CERTIFIES COMPLETION OF COURSE

APPENDIX A

PENNSYLVANIA MOTOR VEHICLE CODE RELATED TO DRINKING & DRIVING (ACT 81)

There are a number of provisions within the Motor Vehicle Code which comprise the Commonwealth's policy addressing the problem of drinking and driving. The following is a summary of the various provisions.

Section 3731 – defines driving under the influence of alcohol or controlled substances as a serious traffic offense. The use of alcohol, controlled substances, or the combination of either to a degree which renders a person incapable of safe driving is prohibited and classified as a third degree misdemeanor. The authorized use of such cannot be used as a defense (i.e., prescription usage); and an officer may arrest if he has reason to suspect alcohol or drug influence.

Section 1532 (a) (2) and Section 1532 (b) (2) – stipulates penalties to a maximum of $2,500 for violation and conviction under Section 3731. On the first offense conviction the department must suspend the license for six months. If there is a second conviction within three years, the department ***must*** revoke the license for one year.

Section 1540 (a) – requires in cases of mandatory revocation (as provided above) that the court or the district attorney require surrender of the license, and the commencement date for suspension or revocation begins on the date the license is received by the court or the department.

Section 1534 – allows that Accelerated Rehabilitative Disposition (ARD) be offered for violations of Section 1532, however use of ARD must be considered in determining subsequent suspensions (Section 1539 (c)).

Section 1542 (a) and (b) – defines "***habitual offenders.***" Basically, if a person was convicted of driving under the influence three times within a five year period, they would be classified as an habitual offender and subject to an automatic five year revocation.

The very specific provisions dealing with driving under the influence are found in Section 1547, 1548 and 1549.

Provisions in those sections are outlined below.

Section 1547 – Chemical Test to Determine Amount of Alcohol:

- Consent to alcohol blood level testing is implicit in holding a license.
- Tests must be administered by physician, technician, or trained police officer.
- If a person refuses to submit to test, the test will not be given but there will be an automatic six months suspension for refusing and an automatic one year suspension for a second refusal.
- Police officer must notify the person of consequences of refusal.
- Results of the test are admissable as evidence in summary or criminal proceedings.
- If tests show:

  .05 or less = the finding will conclude that the person is not under influence and there will be no charge under 3731 (1) (2).

  .06 – .09 = there will be no conclusive finding but in combination with other evidence it could be proven that there was alcohol influence.

  .10 or more = there is a presumption of influence.

- If a person is unable to give enough breath for test, blood may be taken. Same provisions on test results as evidence and for refusals apply for blood tests as for breath tests.
- Person shall be permitted to have the test administered by their personal physician and results are admissable.
- Person may request test if involved in an accident and request is to be honored when possible.
- Persons administering tests and hospitals employing such persons are immune from civil liability.

Section 1548 – Post Conviction Examination for Driving Under Influence:

- Requires the court to conduct a pre-sentencing examination to determine if the person needs treatment for alcohol or drug abuse. If the exam indicates a treatment need then the court may order out-patient treatment or commitment to a facility approved by the Governor's Council on Drug and Alcohol Abuse. The exam is carried under provisions of the MH/MR Act of 1966.

- The pre-sentencing exam applies only to second or subsequent offenses within five years.

- The person may be examined by a doctor of their choice and results may be presented to the court.

- The court may also, upon petition, review the order of commitment.

Section 1549 (b) – Establishment of Schools requires the Department of Transportation in conjunction with the Governor's Council on Drug and Alcohol Abuse to establish and maintain an educational course on the problems of alcohol and driving throughout the Commonwealth.

APPENDIX B

Selected References:

A Survey of Court Procedures for Handling Problem Drinkers Convicted of Driving While Intoxicated. Available from National Technical Information Service, Springfield, Virginia 22151. Order (FH-11-7580 – Six Volumes).

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Rouse, Kenneth A. "The Way To Go" Kemper Insurance Company, 1975.

Rx: First Aid for the Drunken Driver Begins in Your Office. GPO 717-793. Revised June 1973. U.S. Department of Transportation, NHTSA.

San Diego Police Department. ***Drinking Driver Enforcement Squad.*** San Diego: 1971.

"Studies on Drinking and Driving," ***Quarterly Journal of Studies on Alcohol, Supplement No. 4*** May 1968. Selden D. Bacon, Ph.D. Special Edition. Available from Editorial Office, Center for Alcohol Studies, Rutgers University, New Brunswick, New Jersey 08903. Single copy cost $4.50.

The Problem Drinking Driver: A Legal Perspective. Available from National Technical Information Service, Springfield, Virginia 22151. Order (FH-11-7270).

Traffic Institute, Northwestern University. ***Driving Under Influence of Alcohol or Drugs.*** Evanston, Illinois: 1966.

U.S. Department of Transportation. ***Highway Safety Program Manual.*** Vol. 8, Alcohol in Relation to Highway Safety, NHSB, January 1969.

APPENDIX C

Pennsylvania Alcohol-Highway Safety Program Judicial, Counseling and Rehabilitation, County Officials, and Education Program Reference List:

All of the Manuals for the Pennsylvania Alcohol-Highway Safety Program can be obtained from the Pennsylvania Department of Transportation – Highway Safety Group:

Pennsylvania Alcohol-Highway Safety Program – Judicial Manual: Philadelphia; Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

Pennsylvania Alcohol-Highway Safety Program – Counseling and Rehabilitation Manual: Philadelphia; Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

Pennsylvania Alcohol-Highway Safety Program – County Officials Manual: Philadelphia; Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

Pennsylvania Alcohol-Highway Safety Program – Pennsylvania DUI Safe Driving School – Instructors Guide: Philadelphia: Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

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Counseling & Rehabilitation

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PENNSYLVANIA ALCOHOL HIGHWAY SAFETY PROGRAM

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PREFACE

This Counseling and Rehabilitation Manual for the Commonwealth of Pennsylvania has been prepared by International Alcohol and Mental Health Associates, Inc. under the aegis of the City of Philadelphia's Coordinating Office on Drug and Alcohol Abuse Programs, Project Manager, Nicholas Piccone, Ed.D. Contract #6-3113 entitled "Curriculum and Instructors Guide for Use with Persons Arrested for Driving While Intoxicated (DWI)."

This Counseling and Rehabilitation Manual was prepared for The Governor's Council on Drug and Alcohol Abuse, Commonwealth of Pennsylvania and The Pennsylvania Department of Transportation, in conjunction with the National Highway Traffic Safety Administration, Contract #AL 76-10-4.

Project Staff responsible for the preparation of this Manual were: Eric W. Fine, M.D., M.R.C. Psych., Medical Director; Michael J. Mulligan, M.Ed., Clinical Psychologist; Pascal Scoles, D.S.W., Project Director, and Ms. Mary Miller, Administrative Assistant, International Alcohol and Mental Health Associates, Inc.

I. Introduction

A. *An Overview*

In the past 80 years the automobile has managed to gain universal acceptance as the preferred means of transportation for nearly all societies and cultures. It has also become one of the most unusual and sophisticated deadly weapons ever known to mankind. In any given year it has inflicted greater death tolls on the American public than any of the wars fought in recent times. For example, there were approximately 45,000 United States fatalities over a 10 year battle period in Viet Nam, and 52,000 highway deaths in the year of 1972 alone. The startling aspects of these highway fatalities statistics include not only the high percentage of non-driver deaths, but the fact that nearly 50% of these fatalities are considered by experts to be alcohol-related. Yet, it appears that most citizens and governmental leaders are still unaware of, or unable to respond to, the tremendous responsibility to develop innovative personal or organizational responses to this problem.

In the Commonwealth of Pennsylvania, as throughout the United States, the problem exists in various forms and, as local political practices and leadership conditions permit, countermeasures programs have become uniquely local in their responses to the drunken driver problem. In the new Motor Vehicle Code of Pennsylvania (Act 81), Driving Under the Influence of alcohol or controlled substances (DUI) is a third degree misdemeanor. On the first offense (conviction) the Department of Transportation ***must*** suspend the license for six months. If a second conviction occurs within three years, the Pennsylvania Department of Transportation ***must*** revoke the license for one year. "Habitual offenders," defined as a driver with three convictions within a five year period, incur an automatic five year revocation. All offenders can be fined up to a maximum of $2,500.

In the process of apprehension, trial and ultimate disposition of the case, all the costs, except defense, are usually directly laid on the taxpayer. According to a study by Chicago Law Enforcement Officials, the total costs of trials, jury, and prosecution expenses is estimated to be $10,000 per offender. When the costs and ultimate effects of jail and/or probation are included in the disposition process for three years, it could be safely assumed to raise that total by a substantial amount.

The costs to an offender are equally high when considering both personal and financial measures. Lawyers' fees, lost work, automobile retrieval/repair, civil suits for injuries, fines, loss of license, loss of income during incarceration, and special risk automobile insurance after the return of the operator's permit, all combine to create an extremely embarrassing financial and personal consequence of the arrest.

For the genuine "problem drinker" that exists within this drunken driver group, there is, unfortunately, usually no special program awareness of, or attention to, the unique conditions that afflict them, and they are treated "equally under the law" for their marginally controlled behavior. They may receive "special treatment" for multiple arrests if they defy the odds of a fatal accident more than once, but in most cases, they receive the usual penalties unique to the arresting

municipality or area. In most cases they merely consider themselves to be personally "unlucky," and take their penalties equally with their "non-alcoholic" co-offenders with little thought or consideration to their extremely life-threatening situation, and with maximum attention to the "unfairness" of their lot.

Thus, for the police, the courts, the governmental administrators, the alcohol rehabilitation workers, and the highway safety specialists, the marathon goes on and the score goes up.

But it doesn't have to be this way much longer, for the Commonwealth has now changed the rules. The keynote is revision and realization of the available evidence. The revision is in the existing laws relating to drunken driving based on the evidence that ***each*** drunken driver is different from the other, and that options must be expanded to meet the problem, so that prevention and protection are increased for both the offender and for society.

This is what this manual is about; a new look at an old problem. We hope that you as a reader and as a potential victim will be able to use your new impressions to prevent drunken driving and protect yourself, your family, and your community. Most importantly, it cannot be done on a single person level or even with one agency or department. To respond to this problem will require a concerted, cohesive and cooperative agreement between public and private groups, with mutual concern, widespread cooperation, and the trust necessary to achieve a common goal.

B. *The Effect of Blood Alcohol Level on Driving*

After ingestion of any alcohol-containing beverage, the alcohol is chiefly absorbed from the first parts of the small intestine, known anatomically as the duodenum and jejunum. It is distributed throughout all body tissues in direct proportion to their water content. Ninety percent of the alcohol is metabolized, mainly in the liver, and less than 10 percent is excreted in the urine, sweat, or breath.

Alcohol affects all the cells of the body, but the most dramatic results of ingesting ethyl alcohol occur in the nervous system. The central nervous system, especially the brain, is primarily affected by alcohol, with an early apparent stimulation resulting from depression of inhibitory control mechanisms. Discrimination, insight, memory, concentration, and perception are all dulled by alcohol, while speech may become eloquent, and mood swings uncontrolled. Complex behavior patterns are released that depend essentially on the personality of the individual, external stimuli from the environment, and tolerance for the drug. Alcohol seriously diminishes both mental and physical abilities, although when under its effect people typically overestimate their performances. For any given blood alcohol level, the effects of alcohol are more noticeable when the alcohol concentration in the blood is rising than when it is falling. High levels of alcohol concentrations affect the ability to discriminate between lights of different intensities. Narrowing of the visual field occurs and may be particularly dangerous in automobile driving. Resistance to glare is impaired so that the eye requires longer to readjust after exposure to bright lights. Sensitivity to certain colors, especially red, appears to decrease.

Although the question of the effect of alcohol on gross behavioral change is not yet fully resolved, the results are unanimous in showing that driving skills already begin to deteriorate at

blood alcohol levels below 0.05%. This level of alcohol in the blood would be reached, broadly speaking, in a person weighing 190 lbs. who had consumed three (3) 12-ounce beers, or three (3) cocktails containing one ounce each of 86 proof alcohol, within one hour before driving. Although other factors, such as the presence of food in the gastrointestinal tract, influence the rate of entrance of alcohol into the bloodstream, a 120-pound person would achieve a blood alcohol level of 0.05% with less than two (2) 12-ounce bottles of beer, or less than two (2) cocktails containing an ounce of 86 proof alcohol each.

Increasing concentration of alcohol in the blood is related to a number of driving errors, e.g., carelessness, reduced exactitude in steering and braking, more frequent stalling at critical moments, etc. A concentration of 0.05% alcohol in the blood produced a tendency to drive toward a road ditch in 82% of cases studied. With 0.10% blood levels, drivers consistently fluctuated between low and high speeds, swerved from lane to lane, and used excessive amount of time to return to the correct lane. Blood alcohol levels of 0.10% adversely affect normal driver performance by 15%, with deterioration increasing to 30% with blood alcohol levels of 0.15%.

There is no question that the percentage of vehicle accidents increases sharply as the driver's blood alcohol level increases. The chance of accident involvement where blood alcohol levels are between 0.05% and 0.10% is two to seven times greater than persons at zero BAC and at 0.15%, it is approximately 25 times greater. These estimates are given indirect support by studies which show a positive correlation between blood alcohol levels and other serious relevant variables, such as extent of damage, expense of damage, and severity of injury.

C. ***Psychological Factors in Drinking Drivers***

While numerous studies have established that problem drinkers have higher rates of alcohol-related accidents than social drinkers, considerable controversy still exists concerning the responsible factors. Some authorities argue that physiological impairment caused by excessive alcohol intake is the most important factor, while others feel that personality characteristics, such as impulsiveness, hostility and suicidal tendencies exacerbated by alcohol are most significant. It is most likely that a complex interaction of these variables in a particular individual results in a person at high risk becoming involved in an automobile accident. Personality factors in problem drinkers are presumed more important than sensorimotor impairment, while in younger non-alcoholic drivers with the same blood alcohol levels, impairment of sensorimotor functions is primarily responsible.

A full understanding of the problem of the drinking driver requires intensive study of the demographic, social and psychological characteristics of the persons involved. The personality traits observed in intoxicated persons involved in accidents include chronic hostility, depression, feelings of omnipotence, invulnerability, self-destructiveness, egocentricity and decreased tolerance to tension. The significance of suicidal tendencies, unconscious or otherwise, has received particular attention.

Alcohol intoxication might thus be responsible for automobile accidents not only because it impairs sensorimotor functions, but also because of its potential for reducing emotional control and releasing self-destructive impulses. Certain combinations of personality difficulty are highly

predictive of accident potential, and in problem drinkers it appears that an interplay between social or psychological stress, deleterious personality traits which are liberated by alcohol, and the impairment of skill caused by intoxication, is responsible for an excess of traffic accidents in which death may occur.

In summary, it can be stated that tests of overall driving ability become meaningless if only psychomotor concepts are considered. Equally important are the effects of alcohol in reducing inhibitions, altering self-perception and self-confidence, and changing attitudes and value judgments.

D. ***The Management of Drunken Drivers***

The effective management of the population that drinks and drives automobiles is extremely complex, particularly since a significant proportion of DUI offenders have serious alcohol abuse problems over and above that associated with the driving offense. It is highly probable that the great majority of these persons would never have been exposed to public scrutiny or intervention for their drinking behavior had they not been arrested for drunk driving.

Alcoholism itself is not a unitary condition, the "alcoholic population" in any community consists of a large variety of subgroups with many different problems underlying, or secondary to, their dependency on alcohol. Thus, no one type of treatment approach will be applicable to all these groups, and successful management depends on an accurate delineation of the specific drinking syndrome and the organization of appropriate treatment regimens.

Clinical experience strongly suggests that specific treatment techniques will have to be developed for those persons who drive while intoxicated. These may be considerably different from those typically employed in the general field of alcoholism. It is not sufficient for the majority of these subjects to be merely referred to existing alcoholism treatment programs or self-help groups such as Alcoholics Anonymous, as many of them require complex services providing a wide range of treatment modalities, and not just a traditional total abstinence approach. The inability of many criminal justice systems to view DUI offenders as primarily a public health problem has allowed the legal system to operate on a punitive, short-term basis, using indirect punishment such as provoking job loss, fines, jail sentences and license suspension as "preventive" techniques. This approach is intended to reprimand the individual for his deviant behavior, and thereby protect society from a recurrence of that behavior, but frequently only exacerbates the problem.

Data from numerous studies indicate that these methods have had a minimal effect. License suspension, or revocation, is not an effective deterrent. Incarceration is a very expensive and burdensome legal procedure, filling correctional facilities with individuals who seem impervious to short-term jail sentences. Often, it contributes to job loss, which probably increases the chance that alcohol abusers will drink more heavily and therefore be more likely to precipitate traffic accidents. Also, recent figures from California have demonstrated that, in that state, more than one-third of first offenders and one-half of second offenders are ***convicted again*** for driving while intoxicated ***while under suspension or revocation of license.***

The implications of these facts are clear; law enforcement techniques alone are not sufficient to deter repeated drunken-driving offenses, and this failure has contributed to an annual rate of

almost ***30,000 deaths*** and ***15.8 billion dollars*** in property damage and personal injury. The above figures, coupled with the offender's attitude, should force clinical personnel to re-examine the evidence and utilize a special compulsory treatment system that is closely linked to an effective and cooperative judicial system. It is evident, however, that simply to remove this problem from the singular purview of the law will not be effective if appropriate socio-psychological rehabilitation systems do not exist.

In a system which involves law enforcement officials and mental health professionals, there always exists the basic conflict between treatment and punishment. Changing behavior for the benefit of the community should be the mutual objective of both professions, but neither alone has been as effective as it would like to be in accomplishing this. Driving under the influence of alcohol is a classic example of a public health problem that necessitates the creation of a working relationship between the judicial and mental health systems for its effective management.

There are indications that a combined legal-mental health approach would be a viable alternative to punishment, and would enhance the chances of successful rehabilitation. Previous studies dealing with court-committed treatment of some more seriously deteriorated alcoholics have shown an average success rate of 50%. The therapeutic approach would have the same primary goal as the legalistic approach, i.e., of protecting society by preventing the individual from repeating his deviant behavior. Its process would be different, however; it would constructively guide the individual toward a changed pattern of behavior, so that he might exist as a well-functioning element within society.

II. Considerations for Treatment and Rehabilitation Personnel

A. *Diagnosis and Evaluation*

The DUI population has been shown to be heterogenous, and in all probability consists of a number of subgroups, most of which can be classified as problem drinking types. There is, of course, the possibility that a so-called "social drinker" might be arrested for DUI on the basis of an occasional, or even isolated, incident of alcohol abuse. Most research would agree that a significant proportion of DUI offenders can be classified as "problem drinkers" or "alcoholic persons." Depending on the particular group of DUI offenders studied, and the definitions used, this proportion of problem drinkers can range from 50-70% of the studied populations. It might be argued that anyone arrested for DUI has a "drinking problem" of some importance.

The objective of any evaluation procedure is to formulate as effective an individualized countermeasure/rehabilitation plan as possible for each DUI offender. This outcome depends upon an accurate delineation of the individual's drinking pattern, personality profile, and general lifestyle. To accomplish this, it is suggested that the following considerations be made regarding diagnostic assessment.

1) ***Evaluation Instrument*** – Several of these are available, including the Mortimer-Filkins Test; the Michigan Alcoholic Screening Test (MAST); the Short Michigan Alcoholic

Screening Test (SMAST); National Council on Alcoholism (NCA) Criteria for the Diagnosis of Alcoholism; and Johns Hopkins Alcoholism Screening Test. Of these instruments, the most readily available, generally useful, and comprehensive, is the Mortimer-Filkins Test.

All of these instruments are intended to provide an objective evaluation of the DUI offender with special reference to the drinking behavior. The use of such objective instruments is far superior to a more subjective and potentially biased individual impression. All of these instruments do depend, however, on a degree of accuracy and truthfulness on the part of the interviewee. ***In order to obtain some degree of standardization throughout the Commonwealth, it has been strongly recommended that the Mortimer-Filkins Test be adopted as the routine testing measure for countermeasures programs.*** (See Appendix A for Ordering Procedures.)

2) ***Additional Evaluative Indicators*** – There are several supplementary tools that may increase the predictive and diagnostic qualities of the primary measurement instrument. These are as follows:

a) ***Blood Alcohol Concentration (B.A.C.)*** – This is calculated from a measurement of the alcohol content of a sample of expired air from the offender. There is a predictable and constant ratio between the alcohol level in the blood and that in the alveolar air of a subject. It should be noted that a BAC of more than 0.10% in a routine examination is regarded by the Criteria Committee of the National Council on Alcoholism as being clearly and definitely associated with alcoholism. This would imply that every offender arrested for DUI at 0.10% should be considered in a category of alcoholism unless proven otherwise by additional considerations. On this basis, it would certainly seem reasonably to suppose that any person who has been arrested with a BAC of 0.15% or more could be automatically regarded as a serious "problem drinker" or "alcoholic person."

b) ***Previous Arrest Record*** – Any previous arrest for DUI or other alcohol-related offense within the preceding five years should be regarded with a high index of suspicion as suggestive of an "alcoholic person."

c) ***Self Admitted Problem*** – A person voluntarily admitting to "loss of control" over alcohol consumption would lend strong suspicion to the diagnosis of alcoholism.

d) ***Previous Treatment for Alcoholism or Social Problems Related to Alcohol Use*** – A person's self-described or known history of any alcohol-related medical, psychological, or social condition should also be regarded as extremely significant in the diagnosis of alcoholism.

e) ***Measurement of Client Truthfulness*** – It is reasonable to suppose that some of the information obtained from DUI clients may be inaccurate. This could result from deliberate attempts to mislead the interviewer, or in the case of serious alcohol dependency, organic impairment of the brain producing amnesia, alcoholic "blackouts," or inaccurate recall. It is also commonly accepted that many "alcoholic persons" develop extreme denial mechanisms regarding their drinking behaviors and their significance. A number of aids to assess "lie factors" are available. The "Alco-Calculator" can be used to compare police-reported BAC with the client's report of the number of drinks consumed prior to arrest. Should there be a marked discrepancy one can assume

misreporting. The ***Eysenck Personality Inventory (E.P.I.)***, is quick and simply administered and scored instrument, has a specific built in measure of "faking good" responses, and could be incorporated into the interviewer's overall perception of "truthfulness." (See Appendix A.)

Staff Qualifications in the Evaluation Process

Special attention should be paid to the qualifications and characteristics of staff persons selected to conduct and report on evaluations of DUI clients.

The following interviewer characteristics should be sought:

1) Should have received basic training in the areas of alcohol abuse, alcoholism, and highway safety;
2) Reading, writing, and sufficient mathematical skills and verbal communication abilities to prepare reports;
3) Ability to follow standardized directions and procedures;
4) Empathic and sensitive to the population served;
5) Sensitive to the need for, and accountable to, requirements for record confidentiality;
6) Where conditions indicate, a second language may be necessary.

B. ***Collection and Utilization of Diagnostic Findings – DUI Countermeasures Summary Report***

Upon interview completion and the assembly of relevant informational elements, it will then be necessary to compile a summary report containing three major sections: a diagnostic description of suspected degree of alcoholism; a profile of the offender; and recommendations for follow up and disposition.

It must be strongly emphasized at this point that the accuracy of any report is strongly influenced by the quality of the data that is incorporated in its construction. The computer programmer's adage "GIGO" ("garbage in, garbage out") is an especially important consideration for all programs. If any program of alcohol countermeasures is to succeed, it must have an extremely high level of credibility among all levels of the community, from the DUI offender to the highest court official. Therefore, it must be assumed that all elements of data are meticulously protected to insure that every item, from police Breathalyzer report, to the signature on the final report, is objective, accurate, and free from any personal or subjective influences.

While the degree of objectivity of any program that attempts to incorporate highly selective and isolated behavioral events in making a prediction about a person can certainly be attacked as lacking in total scientific validity, it must be argued that successful rehabilitation (and thus prevention) has been reported in some circumstances to be as high as 80% of the cases treated for alcoholism from less impaired groups in industrial settings. This can be contrasted to a California study that showed as many as two-thirds of drivers with revoked licenses (a non-treatment alternative) were known to continue to drive, since they were identified through subsequent arrests or accidents for driving while under revocation. Thus, in the absence of complete, and all-encompassing accuracy, it does appear that an identification and rehabilitation process would be

no less effective than the present maximum license penalty under the Pennsylvania Motor Vehicle Code.

The content of the DUI Countermeasures Diagnostic Report must contain not only several objective controls, but must also be prepared with a consideration of the priorities and needs of the prospective users of the report, and recognition of the various resources available in the offender's community. Therefore, it is recommended that a "matrix" of events be considered in the analysis of various examination elements before planning for intervention/rehabilitation of each person. A sample of this type of analysis is presented below. This matrix might include some of the following items and would, of course, be best designed and tailored to the major demands and concerns of the local countermeasures program.

Dimension	Clinical Diagnostic Indicators:		
	May Not Be A Problem Drinker	Highly Presumptive Evidence of Problem Drinking	Nearly Certain Evidence of Problem Drinking
1) Mortimer-Filkins			
– Questionnaire	11 or less	12-15	16 or more
– Interview	24 or less	25-39	40 or more
– Total Score	39 or less	40-49	50 or more
2) Blood Alcohol Concentration	0.05% to 0.09%	0.10% to 0.19%	0.20% or more
3) Previous DUI Arrest	0	1-2	3+
4) Previous Alcohol Related Arrest	0	1-2	3+
5) Reliability of Information			
– Alco-Calculator to BAC	Consistent	Inconsistent	Extremely Unlikely
– E.P.I. (Form A or B	0-3	4 or 5	6 or more
6) NCA Diagnostic Criteria	Etc.	Etc.	Etc.
7) Etc., etc.	Etc.	Etc.	Etc.

It should be stressed that this matrix and all other such reporting documents must be individually summarized, with only essential and relevant information contained within it. It would be highly unlikely that the total folder of all information in unedited fashion would serve the future user in any significant way. What is most important, is that the findings of the diagnostic procedure should be presented in a clear, brief, and concise fashion. Standardized reporting formats are usually very acceptable to judges, probation officers, and treatment staff. However, special care should be given to avoid highly subjective terms in these reports which carry strong emotional or stereotypical loadings such as "skid row type," "dignified businessman," "weekend boozer," and the like.

Qualifying statements such as, "it is the impression of the Countermeasures Diagnostic staff, that in view of this person's self-reports, and the available evidence, such conditions are frequently found in persons showing (no/highly presumptive/nearly certain) evidence of problem drinking," are very important ingredients in the preparation of such reports. It is the only "fair" statement that can be made from such a limited inquiry and thus avoids sweeping generalizations and potentially damning and/or incorrect conclusions. It must always be remembered that such reports and conclusions are subject to judicial review and must ultimately be reasonable and acceptable to the judge and to the offender if the rehabilitation plan is ever to be accepted. At the same time, it is of equal importance to conduct the most comprehensive and intensive investigation of client behaviors that the state of the art will permit. Therefore, by reviewing and investigating both the offender's official report file, and personally examining the individual, a reasonable estimate of the presence of, suspicion of, or absence of alcoholism can be made by an experienced interviewer.

A personal profile of the offender must be included in the formal summary and should be used throughout the various stages of report construction to be sure that no confusion or error is made in the assembly of all data elements. Key identifiers are always included in the personal profile and should always include name, date of birth, address, date and time of arrest, B.A.C. at arrest/retest, time of B.A.C., police I.D. number, previous arrest summary, disposition of previous DUI offenses, employment status, marital status and number of dependents, race, and any other significant identifier available in the countermeasures area that will assist in preventing confusion or possible mistakes in data collection and record review.

Very specific recommendations for follow up should be included at the conclusion of the summary report. These conclusions should be aimed closely at achieving three major goals. These are:

1) Prevention of further DUI behavior through education and rehabilitation.
2) Alerting judges, probation officers, and treatment staff of the significant ingredients in the offender's history to assist their understanding of the case.
3) Assisting the referral process by specifying distinct types of treatment, or services needed that "fit" the individual's needs and the treatment resources of the local community.

There are several underlying assumptions that must be made in any recommendation to send a person for treatment for alcoholism. Many of these are commonly accepted by most persons, but

several are quite controversial even among very knowledgeable alcoholism professionals. Few will argue that many persons appear to have problems in maintaining control over their use of alcohol. It is also commonly accepted that this "loss of control" phenomenon is not absolute, and varies in degree among different individuals and from time to time. The causes of alcoholism and a singularly successful cure have not been determined at this time. It has been the experience of many persons, both recovering alcoholics themselves, and professionals within the treatment community, that alcoholism can be "treated" with reasonable success and that the symptoms that surround it can be significantly reduced in many cases.

Care must also be taken that no confusion is made in understanding that ***remission of symptoms*** is ***not the same as a cure***. The Governor's Council on Drug and Alcohol Abuse, as well as numerous other national figures and authorities in the field, concede that, at this time, most forms of alcoholism must be considered to be a life-long condition, and numerous relapses and vehement denial are outstanding characteristics of the condition. Thus, many claims of various proponents of specific and universal "cures" must always be regarded with extreme suspicion by any referring agent. However, many techniques and therapies are quite effective for certain persons when they correspond to their ideals and acceptance levels and significant changes in behavior can frequently be expected when conditions are suitable for such changes.

C. ***Treatment Approaches***

Experience both in the field of alcoholism treatment and that of alcohol highway safety has demonstrated that any treatment program must be flexible enough to allow for individual needs, and must have available several modalities of treatment which can be used in multiple combinations. The reason for having such an approach is based on the knowledge that people arrested for DUI, and who may also be problem drinkers, do not constitute a homogeneous group, and therefore might require quite different treatment regimens with extremely different expectations. There is no doubt, for example, that the degree of problem drinking varies from those offenders who are borderline, so far as diagnosis is concerned, to those individuals whose history and examination leave no doubt that they are alcohol addicts.

Some modalities that have been described as especially useful in the treatment of alcoholism are: Group Therapy, Individual Therapy, Family Therapy, Disulfiram (Antabuse®) Therapy, Chemotherapy, and many others. The environment in which these therapies can be best administered is usually determined by an evaluation of patient needs and the availability of community resources. In general, it has been the experience of most DUI Treatment Programs, that an outpatient environment is quite adequate for the majority of DUI patients, but supportive availability of inpatient, detoxication, and residential care units may be of great value.

Group Therapy

In many cases, this would likely be the primary modality utilized. The type of group psychotherapy felt to be best indicated for these clients is a combination of supportive and insight

giving therapy with a maximum of attention begin given to the pathological use of alcohol. Communication content of the group may include present and past life situations, intra and extra-group relationships and, of great importance, relevant and appropriate environmental factors. Positive transference should be encouraged to promote improved functioning of the individuals, and intra-group dependency should be encouraged. Therapists should adopt an active, involved, and empathetic advice-giving role and, where appropriate, should challenge maladaptive defenses or strengthen existing supportive defenses. The group processes found to be most receptive to patients with alcoholism are cohesion, universalization and reality testing, and these processes appear also to be most appropriate for DUI offenders. Socialization outside of the group should be discouraged. Each group should ideally be as homogeneous as possible as determined by personality types and overall treatment goals set for the individual.

Individual Therapy

A number of patients may require individual therapy as well as, or in place of, group therapy. This should be basically client centered with the main concern being the process of behavior change rather than the structure of the personality. It should concern itself with the use of alcohol as an escape mechanism. The therapist's attitude should be empathetic, non-moralistic and genuine. This type of therapy is particularly appropriate for those patients who are unable, or do not desire, to share their problems with others in a relatively open group setting. This situation could arise because of the particularly sensitive nature of their problem, or because of their inability to relate on any intimate level with a group of relative strangers.

Family Therapy/Couples Therapy

This modality is of potential benefit to those patients who will permit the involvement of their families in the treatment process. This is completely dependent on the voluntary approval and assistance of the patient and their family in assisting the treatment process. Very often the involvement of the family in the therapeutic process will be an important variable in influencing change. Where possible, consideration should always be given to the involvement of the family and multiple attempts should be made, as time and treatment progress, in attempting to secure this involvement. Some special considerations that suggest the inclusion of family therapy include marital problems, disturbed children, and/or verbalized distress of a spouse.

Disulfiram (Antabuse®) Therapy

Disulfiram is a medication which acts as a deterrent to the use of alcohol. Its mechanism of action is to prevent the breakdown of alcohol so that accumulation of a toxic substance (acetaldehyde) occurs in the body. When alcohol is taken by a patient who is established on a disulfiram regimen, this substance produces a range of extremely unpleasant symptoms.

This may be an extremely useful aid in the management of selected alcoholic patients who desire a controlled state of abstinence from alcohol. No patient should be given disulfiram in the

presence of severe heart disease, psychosis, or if unable to fully understand the complex implications of the therapy. Obviously, a physician must evaluate the patient and maintain responsibility for prescribing and supervising the disulfiram therapy. It should be emphasized that ***disulfiram should only be used as a part of a more comprehensive rehabilitation program***, as repeated reinforcement for its continued use must be given, and failure to respond to its use is generally associated with the absence of a well-defined and supportive therapy plan.

Chemotherapy

The presence of associated psychiatric symptoms such as depression or anxiety will determine the need for and use of appropriate anti-depressants and/or tranquilizers. The potential for abuse of the latter type of medication should be a prime concern, with prescriptions being given for small quantities and careful monitoring by the responsible physician and treatment staff.

III. Current Treatment for DUI Offenders in the Commonwealth and Recommendations for Program Development

So far as is known, there are few organized and coordinated systematic treatment programs for DUI offenders in Pennsylvania. In the City of Philadelphia, as a result of some basic research and experience, a need was demonstrated for a treatment program specially designed for problem drinkers in this population, and in 1976 four such special treatment programs are in existence. Also, in Reading, a need for treatment services was recognized, but because of the relatively small number of offenders, their objectives were accomplished within the structure of existing alcoholism treatment programs. In both these cities, the identification and evaluation of the DUI population has resulted in very substantial increases in the referral and admission of alcoholic persons to these alcoholism facilities. In most of Pennsylvania however, there is not only a paucity of alcoholism treatment services in general, but a critical shortage of services for specific groups of alcoholic patients, such as alcoholic DUI offenders.

Throughout the Commonwealth there is a limited number of Alcohol Highway Safety Countermeasures Programs, but the existing programs are, in nearly all cases, essentially educational in nature and do not emphasize, nor conduct, specific treatment on a formal basis. If treatment is mentioned at all it is within the context of a group experience and it is invariably simply a referral or suggestion to attend an Alcoholics Anonymous open meeting, which for most DUI offenders who are earlier stage problem drinkers, may be an inappropriate modality. This is partly because of the anonymity required within the organization itself, which, by organizational philosophy, prohibits developing an accurate recording and reporting between Alcoholics Anonymous groups and the criminal justice system.

Another problem is that most existing alcoholism treatment systems emphasize inpatient treatment, which does not seem to be the most appropriate environment for the vast majority of

the alcoholic DUI offenders. The experience of pilot and developing programs strongly supports the notion that these persons require outpatient approaches that are specially tailored to their needs. Treatment programs for these persons will have to relate to the special conditions of this group, that reflect their special characteristics and needs.

Current research with the DUI population suggests that these persons are, generally speaking, less alcohol-impaired than the type of patient usually seen in alcoholism treatment programs. They are typically male, more often married and living with their spouses, more likely to have good employment records with continuous employment, and have shorter histories of problem drinking than customarily seen in generally voluntary admissions to alcoholism treatment. Although these characteristics would suggest a better prognosis, they are counterbalanced by a significantly poorer motivation to attend and commit oneself to an enduring treatment plan. It is, therefore, very important that a treatment program become mandatory and that the full support of the criminal justice and probation system be mobilized to ensure offender participation in treatment.

The results of a pilot demonstration program for alcoholic DUI offenders conducted in Philadelphia in 1975, suggested that, for meaningful behavior changes to occur, once weekly treatment for six months is the minimum involvement, and it would probably be more desirable to insist on approximately one year of weekly therapy sessions to more fully implement significant, long-lasting behavior change.

There is also a critical need to provide appropriate training for Alcoholism Treatment personnel who are to be involved with the alcoholic DUI offender. They must be made fully aware of the total system in which they are to operate. This means that at least part of their training should occur in association with staff of other components of the Pennsylvania Alcohol-Highway Safety Program. This includes police, probation officers, judges, educators, and administrative officials who each contribute to a comprehensive program of this nature. There are significant differences in the treatment approaches that one might have to adopt for the alcoholic DUI offender than with other kinds of alcoholic populations. The relatively early stages of alcoholism that are characteristic of this group imply that the "rock bottom" approach may not only be inappropriate, but also counter-therapeutic, in the sense that one may be introducing a damaging self-fulfilling prophesy. It has been unfortunately the case in our culture that most alcoholic patients have not entered treatment until there has been significant social and physical deterioration. Therefore, the traditional approaches which might apply to this latter category of alcoholic patient might not be indicated or necessary for these persons arrested for DUI. This implication must be included in any training program where an approach based on the availability of multiple treatment modalities, used in flexible combinations, should be emphasized.

Any treatment program for alcoholic DUI offenders should be seen as an integral part of a total system, under the control and leadership of a single local coordinating authority. The treatment system must link with, and provide continuity of care from the judicial, probation and parole, and educational components, and should also be closely allied to existing alcohol and general health care delivery systems. There are many different ways in which this could be

accomplished, and in each community the DUI treatment system should become part of the local health care delivery system with special ties to both Drug and Alcohol, and Mental Health Programs. The vitally important part played by the local criminal justice system, which will include police, judges, prosecutors, defenders, and probation and parole officers cannot be overemphasized. ***It is strongly recommended that a specific training program involving all these multidisciplinary components should be organized by any community interested in developing an alcohol-highway safety countermeasures program, and should occur at the earliest possible stage of program development.***

IV. Past, Present, and Future Directions for DUI Countermeasures

Over the past 80 years of driving legislation, there have been few attempts to legislate drunk driving prevention into the Motor Vehicle Code of Pennsylvania.

The Federal Government and the United States Department of Transportation have for many years studied the problem of drunk driving, and after the preparation of a special report to Congress in 1968, made several significant recommendations designed to improve prevention in this area. These recommendations were included in the model traffic code known as the Uniform Motor Vehicle Code which has served as the base for the newly enacted Pennsylvania Motor Vehicle Code of 1976, which significantly updates the law in nearly all aspects of traffic safety.

It is now apparent that a more balanced approach to the problem will be adopted, with the recognition that the criminal justice system and the treatment and rehabilitation systems must become partners in any meaningful efforts to reduce the effects of this major public health problem.

Some technological developments are sure to have a marked effect on drunk driving detection and rehabilitation in the coming decade. Portable pre-arrest screening devices are already perfected for police patrol and when such easily utilized instruments are in the hands of the law enforcement officers, a major obstacle to initial identification of the drunken driver will be overcome. The increased organization and standardization of DUI countermeasures in Pennsylvania is sure to have a marked effect on the development of improved administrative and clinical procedures in the management of the problem. Some possible approaches in treatment would include mandatory disulfiram therapy for repeat or resistant offenders, increased use of weekend or evening incarceration, and extensive use of Accelerated Rehabilitative Disposition (ARD). Also, the use of sophisticated breath analysis techniques should be encouraged in all programs involved in evaluation, treatment, and rehabilitation of selected DUI offenders. Such technology will help to refine diagnosis, and objectify and standardize alcohol abuse behaviors. This will facilitate clear communication, and therefore foster relationships between rehabilitation staff and the DUI offender. Technology advances are especially important in the use of accurate and understandable measures of condition and progress shared by the therapist with the client.

Of great significance is the growing emphasis on the quality of alcoholic treatment facilities themselves. Standards for operation and licensing as well as national accreditation for alcoholism treatment programs are now a reality. It is also apparent that this process will accelerate the demise of many marginal and ineffective programs and encourage high administrative and clinical standards for the surviving few. Any form of national health insurance is sure to be linked to the most advanced treatment systems, and payment for any such services will certainly be associated with accredited programs with strong outpatient and aftercare elements.

V. Program Interrelationships

While there are clearly differences in programs operating within the various communities in the Commonwealth, it is apparent that some basic elements must always exist in order to conduct any effective countermeasures program; simply stated, they are law enforcement, judiciary, and rehabilitation. The following flowchart is provided to give a graphic illustration of a fully functioning and comprehensive countermeasures program in the Commonwealth of Pennsylvania.

PENNSYLVANIA ALCOHOL-HIGHWAY SAFETY PROGRAM (PAHSP)

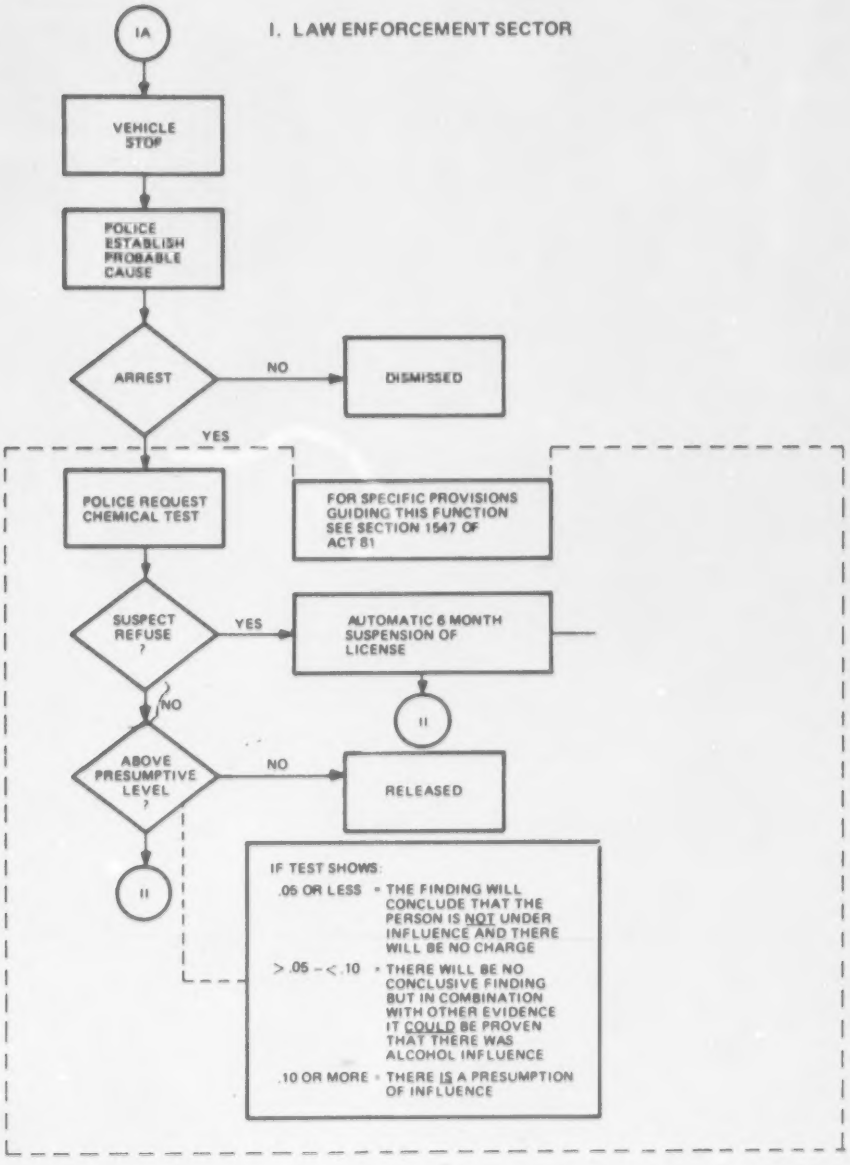
FLOWCHART

I. LAW ENFORCEMENT SECTOR
   - IA. Arrest Process

II. JUDICIAL SECTOR
   - IIA. District Attorney Pre-Trial Screening
   - IIB. Trial Proceedings
   - IIC. Post-Diagnostic Court Ruling

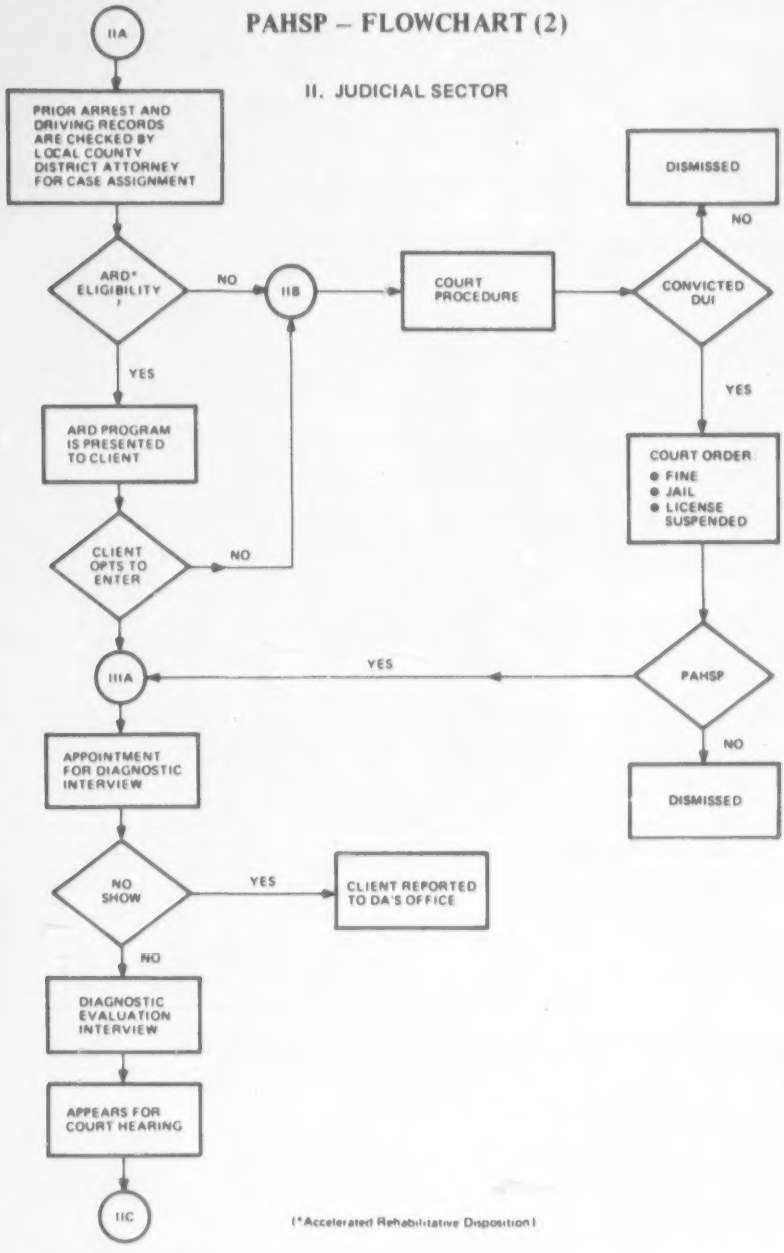
III. REHABILITATION SECTOR
   - IIIA. Diagnostic Evaluation
   - IIIB. Psycho-Medical Treatment
   - IIIC. PAHSP Safe Driving School

PAHSP – FLOWCHART (1)


I. LAW ENFORCEMENT SECTOR
IA
VEHICLE STOP
POLICE ESTABLISH PROBABLE CAUSE
ARREST
NO
DISMISSED
YES
POLICE REQUEST CHEMICAL TEST
FOR SPECIFIC PROVISIONS GUIDING THIS FUNCTION SEE SECTION 1547 OF ACT 81
SUSPECT REFUSE ?
YES
AUTOMATIC 6 MONTH SUSPENSION OF LICENSE
II
NO
ABOVE PRESUMPTIVE LEVEL ?
NO
RELEASED
II
IF TEST SHOWS:
.05 OR LESS - THE FINDING WILL CONCLUDE THAT THE PERSON IS NOT UNDER INFLUENCE AND THERE WILL BE NO CHARGE
> .05 – < .10 - THERE WILL BE NO CONCLUSIVE FINDING BUT IN COMBINATION WITH OTHER EVIDENCE IT COULD BE PROVEN THAT THERE WAS ALCOHOL INFLUENCE
.10 OR MORE - THERE IS A PRESUMPTION OF INFLUENCE

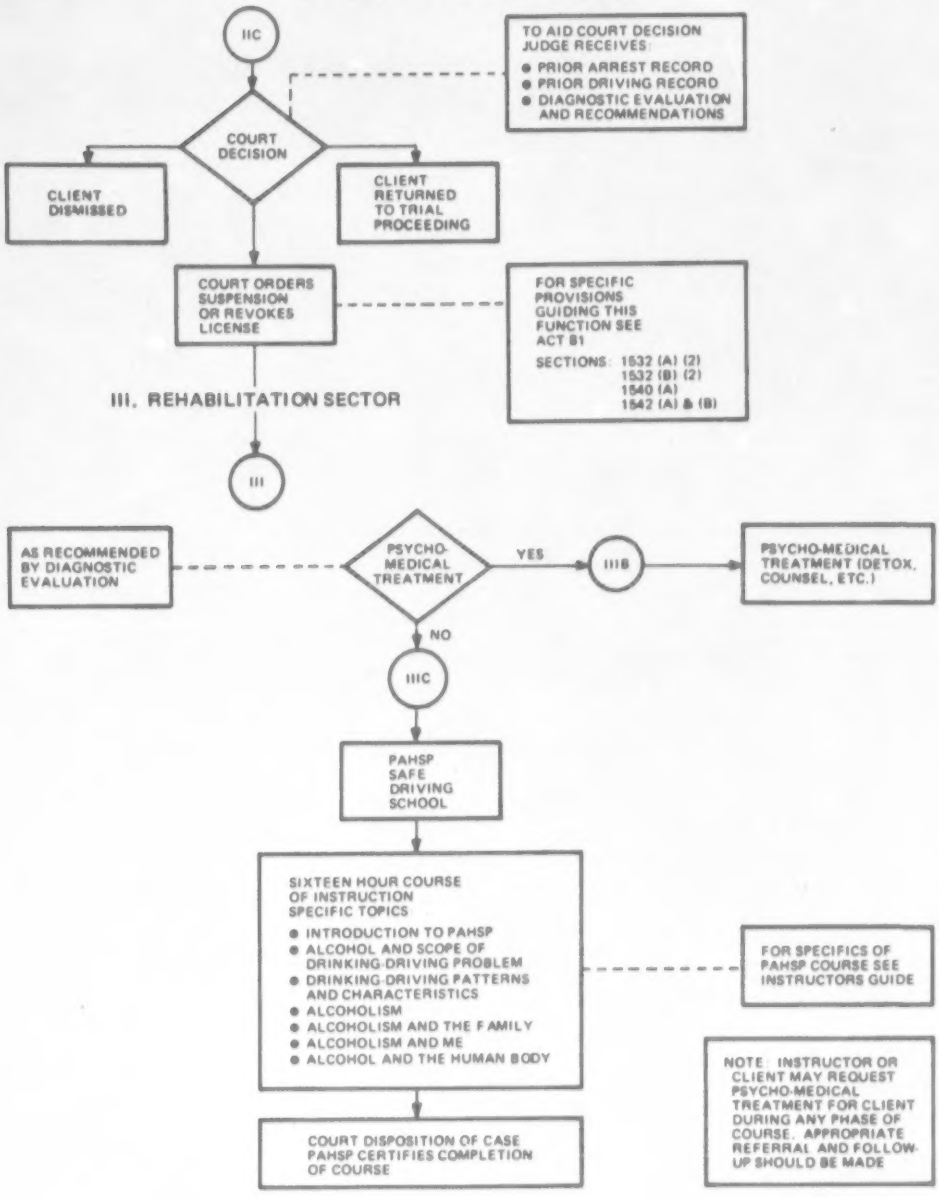
PAHSP – FLOWCHART (2)

II. JUDICIAL SECTOR



(*Accelerated Rehabilitative Disposition)

PAHSP – FLOWCHART (3)


IIC
TO AID COURT DECISION JUDGE RECEIVES:
• PRIOR ARREST RECORD
• PRIOR DRIVING RECORD
• DIAGNOSTIC EVALUATION AND RECOMMENDATIONS
COURT DECISION
CLIENT DISMISSED
CLIENT RETURNED TO TRIAL PROCEEDING
COURT ORDERS SUSPENSION OR REVOKES LICENSE
FOR SPECIFIC PROVISIONS GUIDING THIS FUNCTION SEE ACT 81
SECTIONS: 1532 (A) (2)
1532 (B) (2)
1540 (A)
1542 (A) & (B)
III. REHABILITATION SECTOR
III
AS RECOMMENDED BY DIAGNOSTIC EVALUATION
PSYCHO-MEDICAL TREATMENT
YES
IIIB
PSYCHO-MEDICAL TREATMENT (DETOX, COUNSEL, ETC.)
NO
IIIC
PAHSP SAFE DRIVING SCHOOL
SIXTEEN HOUR COURSE OF INSTRUCTION SPECIFIC TOPICS
• INTRODUCTION TO PAHSP
• ALCOHOL AND SCOPE OF DRINKING-DRIVING PROBLEM
• DRINKING-DRIVING PATTERNS AND CHARACTERISTICS
• ALCOHOLISM
• ALCOHOLISM AND THE FAMILY
• ALCOHOLISM AND ME
• ALCOHOL AND THE HUMAN BODY
FOR SPECIFICS OF PAHSP COURSE SEE INSTRUCTORS GUIDE
NOTE: INSTRUCTOR OR CLIENT MAY REQUEST PSYCHO-MEDICAL TREATMENT FOR CLIENT DURING ANY PHASE OF COURSE. APPROPRIATE REFERRAL AND FOLLOW-UP SHOULD BE MADE
COURT DISPOSITION OF CASE PAHSP CERTIFIES COMPLETION OF COURSE

APPENDIX A

Clinical/Diagnostic Information:

Court Procedures for Identifying Problem Drinkers: Volume 1: Manual: by Margaret W. Kerlan, Rudolf G. Mortimer, Barbara Mudge & Lyle D. Filkins, Highway Safety Research Institute, University of Michigan, Ann Arbor, Michigan 48105, June 1971, National Highway Traffic Safety Administration U.S. Department of Transportation, Publication No. DOT-HS-800-632, Washington, D.C. 20591, available from National Technical Information Service, U.S. Department of Commerce/5285 Port Royal Road, Springfield, Virginia 22151 (Order Revised Version PB 209-959) Price $4.50.

This volume contains the format known commonly as the Mortimer-Filkins Test.

Court Procedures for Identifying Problem Drinkers: Volume 2: Supplementary Readings: by Barbara Mudge, Margaret W. Kerlan, David V. Post, Rudolph G. Mortimer, Lyle D. Filkins; Highway Safety Research Institute, The University of Michigan, Ann Arbor, Michigan 48105, June 1971; available from the National Highway Traffic Safety Administration, U.S. Department of Transportation, Washington D.C. 20591 (See above for NTIS ordering information).

*A special source document is available from NHTSA for use with the Mortimer-Filkins Test which is a ***must*** since it contains scoring keys and procedures but is only available after the program is given official clearance. There are no copyrights involved and Dr. Mortimer does not object if test users make duplicate copies of the test form for legitimate use.

NHTSA Regional Offices for ***Region III*** which covers all of Pennsylvania is:

Airport Plaza Building Room D-203
6701 Elkridge Landing Road
Linthicum, Maryland 21090

Diagnosis and Assessment of Alcohol Abuse and Alcoholism: A Report to the National Institute on Alcohol Abuse & Alcoholism: by George R. Jacobson, Ph.D., Director, Research, Evaluation and Training; DePaul Rehabilitation Hospital, Milwaukee, Wisconsin. Limited quantities available free from the National Clearinghouse for Alcohol Literature and Information (NCALI), P.O. Box 1156, Rockville, Maryland 20850, Phone: (301) 948-4450.

Eysenck Personality Inventory: by H.J. Eysenck and Sybil B.G. Eysenck, may be purchased from Educational and Industrial Testing Service, P.O. Box 7234, San Diego, California, 92107.

– Test Booklets (2 forms, A & B), Scoring Keys, and Testing Manuals required.

Fine, Eric W. and Pascal Scoles. "Secondary Prevention of Alcoholism Using a Population of Offenders Arrested for Driving While Intoxicated (D.W.I.)" in ***Work in Progress on Alcoholism.*** (Eds.) F. Seixas and S. Eggleston New York: Annals of the New York Academy of Sciences. Volume 273, 1976, pp. 637-645.

National Council on Alcoholism Criteria for the Diagnosis of Alcoholism: copies available at Criteria Committee, NCA, 2 Park Avenue, New York, New York 10016 at $1.00 per copy. The complete criteria were published in the ***American Journal of Psychiatry***, 1972, 129, 127-135 and ***Annals of Internal Medicine***, 1972, 77, 249-258 and it is recommended that users have the entire source document because it contains the complete criteria and extremely important information on its use, and necessary information on how to write a diagnosis based on uniform nomenclature.

APPENDIX B

Selected Reference List:

Alcohol and Alcoholism: Problems, Programs, and Progress, NIMH, NIAAA, DHEW Publication No. (HSM) 72-9127, Revised 1972, Available from the National Clearinghouse for Alcohol Literature and Information (NCALI), P.O. Box 1156, Rockville, Maryland 20850, Phone: (301) 948-4450.

1968 Alcohol and Highway Safety Report: A Study Transmitted by the Secretary of the Department of Transportation to the Congress, in accordance with the Requirements of Section 204 of the Highway Safety Act of 1966, Public Law 89-564; August 1968, U.S. Government Printing Office 1968 (98-1760) Committee Print 90th Congress, 2d Session.

American Medical Association, Committee on Medicolegal Problems. ***Alcohol and the Impaired Driver.*** Chicago: American Medical Association, 1968.

Comprehensive Community Services for Alcoholics, The Williamsburg Papers, February 1969, Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, Price 65¢. Limited quantities available free from NCALI.

Erwin, Richard E. ***Defense of Drunk Driving Cases.*** Third Edition. Albany: Matthew Bender, 1971.

Facts About Alcohol and Alcoholism, NIAAA, DHEW Publication (ADM) 75-31, Printed 1974, Reprinted 1975, U.S. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 – Price 85¢. Stock Number 017-024-00351 4 Catalogue No. HE 208302:F11 Also available free in limited quantities from NCALI.

Fine, E. and P. Scoles. "Alcohol, Alcoholism and Highway Safety." ***Public Health Reviews*** (Israel) 1974, pp. 423-[illegible].

Fine, E., P. Scoles, and M. Mulligan. "Under the Influence. . . ." ***Public Health Reports***, Vol. 90, Sept/Oct. 1975, pp 424-429.

From Program to People: Towards a National Policy on Alcoholism Services and Prevention. NIAAA, DHEW Publication No. (ADM) 75-155, Printed 1974, available from NCALI.

Proceedings of the 6th International Conference on Alcohol, Drugs, and Traffic Safety, Toronto, Canada, September 8-13, 1974, Edited by S. Israelstam and S. Lambert; Addiction Research Foundation of Ontario, 33 Russell Street, Toronto, Canada M5S2S1 (Order No. P-240, Clothbound $20.00).

Rx: First Aid for the Drunken Driver Begins in Your Office: GPO 717-793, Revised June 1973, U.S. Department of Transportation, NHTSA.

Second Special Report to the U.S. Congress on Alcohol and Health from the Secretary of Health, Education and Welfare, Morris E. Chafetz, M.D., Chairman of the Task Force. U.S. Government Printing Office, Washington, D.C. Alcohol and Highway Safety Section, pp. 127-144. Limited quantities available free from NCALI

Seixas, F. and S. Eggleston (Eds.) ***Work in Progress on Alcoholism.*** New York: Annals of the New York Academy of Sciences, 1976.

"Studies on Drinking and Driving," ***Quarterly Journal of Studies on Alcohol, Supplement No. 4,*** May 1968, Selden D. Bacon Ph.D., Special Editor, available from Editorial Office, Center for Alcohol Studies, Rutgers University, New Brunswick, New Jersey 08903, Single copy cost $4.50.

APPENDIX C

Treatment Resources in Pennsylvania

Alcoholism Treatment Facilities Directory, published by Alcohol and Drug Problems Association of North America, 1130 Seventeenth Street N.W., Washington, D.C. 20036. 1-10 copies $7.50 plus 50¢ mailing per copy. While published in 1973, it is the most comprehensive listing of almost all state and local programs available.

Facilities Directories within a specific geographic area should be available at the Office of the Drug and Alcohol Authority for your county which would be listed in the Yellow Pages under Social Services.

Additionally, the Local Council of the National Council on Alcoholism also maintains a resource file on local Alcoholism Treatment Facilities in the Council's area and are listed in the telephone White Pages under National Council on Alcoholism.

If the above resources prove inadequate, the Governor's Council on Drug and Alcohol Abuse maintains an information clearinghouse known as ENCORE (717) 787-9761 located at the Riverside Office Building-One, 2101 North Front Street, Harrisburg, Pennsylvania 17110, for special information needs.

Additionally, there are four Division Offices located in four regions of Pennsylvania with staff available for special information and consultation needs. These offices are:

Division Office I
Mr. Jacob Armstrong, Chief
Alcohol Institute
915 Corinthian Avenue
Philadelphia, Pa. 19130
(215) 232-5550

Division Office II
Ms. Camille Fidrych, Chief
43 Main Street
Pittston, Pa. 18640
(717) 655-6801

Division Office III
Ms. Ellen Shoemaker, Chief
Riverside Office Center #2
2101 North Front Street
Harrisburg, Pa. 17120
(717) 783-8307

Division Office IV
Ms. Toni Williams, Chief
3406 Fifth Avenue, 3rd Floor
Pittsburgh, Pa. 15213
(412) 565-5765

APPENDIX D

List of Participants and/or Consultants Assisting in the Preparation of the Counseling and Rehabilitation Manual were:

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Mr. John Riggan
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Philadelphia Coordinating Office on Drug & Alcohol Abuse Programs

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Drug & Alcohol Specialist
Delaware County Drug and Alcohol Planning Council

Mr. Charles A. Brower*
Alcoholism Consultant

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APPENDIX E

Pennsylvania Alcohol-Highway Safety Program Judicial, Law Enforcement, County Officials, and Education Program Reference List:

All of the Manuals for the Pennsylvania Alcohol-Highway Safety Program can be obtained from the Pennsylvania Department of Transportation – Highway Safety Group:

Pennsylvania Alcohol-Highway Safety Program – Judicial Manual: Philadelphia: Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

Pennsylvania Alcohol-Highway Safety Program – Law Enforcement Manual: Philadelphia: Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

Pennsylvania Alcohol-Highway Safety Program – County Officials Manual: Philadelphia: Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

Pennsylvania Alcohol-Highway Safety Program – Pennsylvania DUI Safe Driving School – Instructors Guide: Philadelphia: Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

APPENDIX F

PENNSYLVANIA MOTOR VEHICLE CODE RELATED TO DRINKING & DRIVING (ACT 81)

There are a number of provisions within the Motor Vehicle Code which comprise the Commonwealth's policy addressing the problem of drinking and driving. The following is a summary of the various provisions.

Section 3731 – defines driving under the influence of alcohol or controlled substances as a serious traffic offense. The use of alcohol, controlled substances, or the combination of either to a degree which renders a person incapable of safe driving is prohibited and classified as a third degree misdemeanor. The authorized use of such cannot be used as a defense (i.e., prescription usage); and an officer may arrest if he has reason to suspect alcohol or drug influence.

Section 1532 (a) (2) and Section 1532 (b) (2) – stipulates ***penalties*** to a maximum of $2,500 for violation and conviction under Section 3731. On the first offense conviction the department ***must*** suspend the license for six months. If there is a second conviction within three years, the department ***must*** revoke the license for one year.

Section 1540 (a) – requires in cases of mandatory revocation (as provided above) that the court or the district attorney require surrender of the license, and the commencement date for suspension or revocation begins on the date the license is received by the court or the department.

Section 1534 – allows that Accelerated Rehabilitative Disposition (ARD) be offered for violations of Section 1532, however use of ARD must be considered in determining subsequent suspensions (Section 1539 (c)).

Section 1542 (a) and (b) – defines ***"habitual offenders."*** Basically, if a person was convicted of drinking under the influence three times within a five year period, they would be classified as an habitual offender and subject to an automatic five year revocation.

The very specific provisions dealing with driving under the influence are found in Section 1547, 1548 and 1549.

Provisions in those sections are outlined below.

Section 1547 – Chemical Test to Determine Amount of Alcohol:

- Consent to alcohol blood level testing is implicit in holding a license.
- Tests must be administered by physician, technician, or trained police officer.
- If a person refuses to submit to test, the test will not be given but there will be an automatic six months suspension for refusing and an automatic one year suspension for a second refusal.
- Police officer must notify the person of consequences of refusal.
- Results of the test are admissable as evidence in summary or criminal proceedings.

- If tests show:
  - .05 or less = the finding will conclude that the person is not under influence and there will be no charge under 3731 (1) (2).
  - .06 – .09 = there will be no conclusive finding but in combination and other evidence it could be proven that there was alcohol influence.
  - .10 or more = there is a presumption of influence.
- If a person is unable to give enough breath for test, blood may be taken. Same provisions on test results as evidence and for refusals apply for blood tests as for breath tests.
- Person shall be permitted to have the test administered by their personal physician and results are admissable.
- Person may request test if involved in an accident and request is to be honored when possible.
- Persons administering tests and hospitals employing such persons are immune from civil liability.

Section 1548 – Post Conviction Examination for Driving Under Influence:

- Requires the court to conduct a pre-sentencing examination to determine if the person needs treatment for alcohol or drug abuse. If the exam indicates a treatment need then the court may order outpatient treatment or commitment to a facility approved by The Governor's Council on Drug and Alcohol Abuse. The exam is carried under provisions of the MH/MR Act of 1966.
- The pre-sentencing exam applies only to second or subsequent offenses within five years.
- The person may be examined by a doctor of their choice and results may be presented to the court.
- The court may also, upon petition review the order of commitment.

Section 1549 (b) – Establishment of Schools requires the Department of Transportation in conjunction with The Governor's Council on Drug and Alcohol Abuse to establish and maintain an educational course on the problems of alcohol and driving throughout the Commonwealth.

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Local Officials

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PENNSYLVANIA ALCOHOL HIGHWAY SAFETY PROGRAM

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PREFACE

This County Officials Manual for the Commonwealth of Pennsylvania has been prepared by International Alcohol and Mental Health Associates, Inc. under the aegis of the City of Philadelphia's Coordinating Office on Drug and Alcohol Abuse Programs, Project Manager, Nicholas Piccone, Ed.D. Contract #6-3113 entitled "Curriculum and Instructors Guide for Use With Persons Arrested for Driving While Intoxicated (DWI)."

This County Officials Manual was prepared for The Governor's Council on Drug and Alcohol Abuse, Commonwealth of Pennsylvania and The Pennsylvania Department of Transportation, in conjunction with the National Highway Traffic Safety Administration, Contract #AL 76-10-4.

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I. An Overview of the Problem

In the past 80 years the automobile has managed to gain universal acceptance as the preferred means of transportation for nearly all societies and cultures. It has also become one of the most unusual and sophisticated deadly weapons ever known to mankind. In any given year it has inflicted greater death tolls on the American public than any of the wars fought in recent times. For example, there were approximately 45,000 United States fatalities over a 10 year battle period in Viet Nam, and 52,000 highway deaths in the year of 1972 alone. The startling aspects of these highway fatalities statistics include not only the high percentage of non-driver deaths, but the fact that nearly 50% of these fatalities are considered by experts to be alcohol-related. Yet, it appears that most citizens and governmental leaders are still unaware of, or unable to respond to, the tremendous responsibility to develop innovative personal or organizational responses to this problem.

In the Commonwealth of Pennsylvania, as throughout the United States, the problem exists in various forms and, as local political practices and leadership conditions permit, countermeasures programs have become uniquely local in their responses to the drunken driver problem. In the new Motor Vehicle Code of Pennsylvania (Act 81), Driving Under the Influence of alcohol or controlled substances (DUI) is a third degree misdemeanor. On the first offense (conviction) the Department of Transportation ***must*** suspend the license for six months. If a second conviction occurs within three years, the Pennsylvania Department of Transportation ***must*** revoke the license for one year. "Habitual offenders," defined as a driver with three convictions within a five year period, incur an automatic five year revocation. All offenders can be fined up to a maximum of $2,500.

In the process of apprehension, trial and ultimate disposition of the case, all the costs, except defense, are usually directly laid on the taxpayer. ***According to a study by Chicago Law Enforcement Officials, the total costs of trials, jury, and prosecution expenses is estimated to be $10,000 per offender. When the costs and ultimate effects of jail and/or probation are included in the disposition process for three years, it could be safely assumed to raise that total by a substantial amount.***

The costs to an offender are equally high when considering both personal and financial measures. Lawyers' fees, lost work, automobile retrieval/repair, civil suits for injuries, fines, loss of license, loss of income during incarceration, and special risk automobile insurance after the return of the operator's permit, all combine to create an extremely embarrassing financial and personel consequence of the arrest.

For the genuine "problem drinker" that exists within this drunken driver group, there is, unfortunately, usually no special program awareness of, or attention to, the unique conditions that afflict them, and they are treated "equally under the law" for their marginally controlled behavior. They may receive "special treatment" for multiple arrests if they defy the odds of a fatal accident more than once, but in most cases, they receive the usual penalties unique to the arresting municipality or area. In most cases they merely consider themselves to be personally "unlucky," and take their penalties equally with their "non-alcoholic" co-offenders with little thought or consideration to their extremely life threatening situation, and with maximum attention to the "unfairness" of their lot.

Thus, for the police, the courts, the governmental administrators, the alcohol rehabilitation workers, and the highway safety specialists, the marathon goes on and the score goes up.

But it doesn't have to be this way much longer, for the Commonwealth has now changed the rules. The keynote is revision and realization of the available evidence. The revision is in the existing laws relating to drunken driving. Based on the evidence that ***each*** drunken driver is different from the other, and that options must be expanded to meet the problem, so that prevention and protection are increased for both the offender and for society.

This is what this manual is about; a new look at an old problem. We hope that you as a reader and as a potential victim will be able to use your new impressions to prevent drunken driving and protect yourself, your family, and your community. Most importantly, it cannot be done on a single person level or even with one agency or department. ***To respond to this problem will require a concerted, cohesive and cooperative agreement between public and private groups, with mutual concern, widespread cooperation, and the trust necessary to achieve a common goal.***

II. The Effect of Blood Alcohol Level on Driving

After ingestion of any alcohol-containing beverage, the alcohol is chiefly absorbed from the first parts of the small intestine, known anatomically as the duodenum and jejunum. It is distributed throughout all body tissues in direct proportion to their water content. Ninety percent of the alcohol is metabolized, mainly in the liver, and less than 10% is excreted in the urine, sweat, or breath.

Alcohol affects all the cells of the body, but the most dramatic results of ingesting ethyl alcohol occur in the nervous system, especially the brain. The central nervous system, especially the brain, is primarily affected by alcohol, with an early apparent stimulation resulting from depression of inhibitory control mechanisms. Discrimination, insight, memory, concentration, and perception are all dulled by alcohol, while speech may become eloquent, and mood swings uncontrolled. Complex behavior patterns are released that depend essentially on the personality of the individual, external stimuli from the environment, and tolerance for the drug. Alcohol seriously diminishes both mental and physical abilities, although when under its effect people typically overestimate their performances. For any given blood alcohol level, the effects of alcohol are more noticeable when the alcohol concentration in the blood is rising than when it is falling. High levels of alcohol concentrations affect the ability to discriminate between lights of different intensities. Narrowing of the visual field occurs and may be particularly dangerous in automobile driving. Resistance to glare is impaired so that the eye requires longer to readjust after exposure to bright lights. Sensitivity to certain colors, especially red, appears to decrease.

Although the question of the effect of alcohol on gross behavioral change is not yet fully resolved, the results are unanimous in showing that driving skills already begin to deteriorate at blood alcohol levels below 0.05%. This level of alcohol in the blood would be reached, broadly speaking, in a person weighing 190 lbs. who had consumed three (3)

12-ounce beers, or three (3) cocktails containing one ounce each of 86 proof alcohol, within one hour before driving. Although other factors, such as the presence of food in the gastrointestinal tract, influence the rate of entrance of alcohol into the bloodstream, a 120-pound person would achieve a blood alcohol level of 0.05% with less than two (2) 12-ounce bottles of beer, or less than two (2) cocktails containing an ounce of 86 proof alcohol each.

Increasing concentration of alcohol in the blood is related to a number of driving errors, e.g., carelessness, reduced exactitude in steering and braking, more frequent stalling at critical moments, etc. A concentration of 0.05% alcohol in the blood produced a tendency to drive toward a road ditch in 82% of the cases studied. With 0.10% blood levels, drivers consistently fluctuated between low and high speeds, swerved from lane to lane, and used excessive amount of time to return to the correct lane. Blood alcohol levels of 0.10% adversely affect normal driver performance by 15%, with deterioration increasing to 30% with blood alcohol levels of 0.15%.

There is no question that the percentage of vehicle accidents increases sharply as the driver's blood alcohol level increases. The chance of accident involvement where blood alcohol levels are between 0.05% and 0.10% is two to seven times greater than persons at zero BAC and at 0.15%, it is approximately (25) times greater. These estimates are given indirect support by studies which show a positive correlation between blood alcohol levels and other serious relevant variables, such as extent of damage, expense of damage, and severity of injury.

III. Psychological Factors in Drinking Drivers

While numerous studies have established that problem drinkers have higher rates of alcohol-related accidents than social drinkers, considerable controversy still exists concerning the responsible factors. Some authorities argue that physiological impairment caused by excessive alcohol intake is the most important factor, while others feel that personality characteristics, such as impulsiveness, hostility and suicidal tendencies exacerbated by alcohol are most significant. It is most likely that a complex interaction of these variables in a particular individual results in a person at high risk of becoming involved in an automobile accident. Personality factors in problem drinkers are presumed more important than sensorimotor impairment, while in younger non-alcoholic drivers with the same blood alcohol levels, impairment of sensorimotor functions is primarily responsible.

A full understanding of the problem of the drinking driver requires intensive study of the demographic, social and psychological characteristics of the persons involved. The personality traits observed in intoxicated persons involved in accidents include chronic hostility, depression, feelings of omnipotence, invulnerability, self-destructiveness, egoncentricity and decreased tolerance to tension. The significance of suicidal tendencies, unconscious or otherwise, has received particular attention.

Alcohol intoxication might thus be responsible for automobile accidents not only because it impairs sensorimotor functions, but also because of its potential for reducing emotional control and releasing self-destructive impulses. Certain combinations of personality difficulty are highly predictive of accident potential, and in problem drinkers it appears that an interplay between social or psychological stress, deleterious personality traits which

are liberated by alcohol, and the impairment of skill caused by intoxication, is responsible for an excess of traffic accidents in which death may occur.

In summary, it can be stated that tests of overall driving ability become meaningless if only psychomotor concepts are considered. Equally important are the effects of alcohol in reducing inhibitions, altering self-perception and self-confidence, and changing attitudes and value judgments.

IV. The Management of Drunken Drivers

The effective management of the population that drinks and drives automobiles is extremely complex, particularly since a significant proportion of DUI offenders have serious alcohol abuse problems over and above that associated with the driving offense. It is highly probable that the great majority of these persons would never have been exposed to public scrutiny or intervention for their drinking behavior had they not been arrested for drunk driving.

Alcoholism itself is not a unitary condition, the "alcoholic population" in any community consists of a large variety of subgroups with many different problems underlying, or secondary to, their dependency on alcohol. Thus, no one type of treatment approach will be applicable to all these groups, and successful management depends on an accurate delineation of the specific drinking syndrome and the organization of appropriate treatment regimens.

Clinical experience strongly suggests that specific treatment techniques will have to be developed for those persons who drive while intoxicated. These may be considerably different from those typically employed in the general field of alcoholism. It is not sufficient for the majority of these subjects to be merely referred to existing alcoholism treatment programs or self-help groups such as Alcoholics Anonymous, as many of them require complex services providing a wide range of treatment modalities, and not just a traditional total abstinence approach. The inability of many criminal justice systems to view DUI offenders as primarily a public health problem has allowed the legal system to operate on a punitive, short-term basis, using indirect punishment such as provoking job loss, fines, jail sentences and license suspension as "preventive" techniques. This approach is intended to reprimand the individual for his deviant behavior, and thereby protect society from a recurrence of that behavior but frequently only exacerbates the problem.

Data from numerous studies indicate that these methods have had a minimal effect. License suspension, or revocation, is not an effective deterrent. Incarceration is a very expensive and burdensome legal procedure, filling correctional facilities with individuals who seem impervious to short-term jail sentences. Often, it contributes to job loss, which probably increases the chance that alcohol abusers will drink more heavily and therefore be more likely to precipitate traffic accidents. Also, recent figures from California have demonstrated that, in that state, more than one-third of first offenders and one-half of second offenders are ***convicted again*** for driving while intoxicated ***while under suspension or revocation of license***.

The implications of these facts are clear; law enforcement techniques alone are not sufficient to deter repeated drunken-driving offenses, and this failure has contributed to an

annual rate of almost ***30,000 deaths*** and ***15.8 billion dollars*** in property damage and personal injury. The above figures, coupled with the offender's attitude, should force clinical personnel to re-examine the evidence and utilize a special compulsory treatment system that is closely linked to an effective and cooperative judicial system. It is evident, however, that simply to remove this problem from the singular purview of the law will not be effective if appropriate socio-psychological rehabilitation systems do not exist.

In a system which involves law enforcement officials and mental health professionals, there always exists the basic conflict between treatment and punishment. Changing behavior for the benefit of the community should be the mutual objective of both professions, but neither alone has been as effective as it would like to be in accomplishing this. Driving under the influence of alcohol is a classic example of a public health problem that necessitates the creation of a working relationship between the judicial and mental health systems for its effective management.

There are indications that a combined legal-mental health approach would be a viable alternative to punishment, and would enhance the chances of successful rehabilitation. Previous studies dealing with court-committed treatment of some more seriously deteriorated alcoholics have shown an average success rate of 50%. The therapeutic approach would have the same primary goal as the legalistic approach, i.e., of protecting society by preventing the individual from repeating his deviant behavior. Its process would be different, however; it would constructively guide the individual toward a changed pattern of behavior, so that he might exist as a well-functioning element within society.

V. Considerations Relevant to Rehabilitation

A. *Diagnosis and Evaluation*

The DUI population has been shown to be heterogenous, and in all probability consists of a number of subgroups, most of which can be classified as problem drinking types. There is, of course, the possibility that a so-called "social drinker" might be arrested for DUI on the basis of an occasional, or even isolated, incident of alcohol abuse. Most research would agree that a significant proportion of DUI offenders can be classified as "problem drinkers" or "alcoholic persons." Depending on the particular group of DUI offenders studied, and the definitions used, this proportion of problem drinkers can range from 50-70% of the studied populations. It might be argued that anyone arrested for DUI has a "drinking problem" of some importance.

The objective of any evaluation procedure is to formulate as effective an individualized countermeasure/rehabilitation plan as possible for each DUI offender. This outcome depends upon an accurate delineation of the individual's drinking pattern, personality profile, and general lifestyle. To accomplish this, it is suggested that the following considerations be made regarding diagnostic assessment.

1) ***Evaluation Instrument*** – Several of these are available, including the Mortimer-Filkins Test; the Michigan Alocholic Screening Test (MAST); the Short Michigan Alcoholic Screening Test (SMAST); National Council on Alcoholism (NCA) Criteria for the Diagnosis

of Alcoholism; and Johns Hopkins Alcoholic Screening Test. Of these instruments, the most readily available, generally useful, and comprehensive is the Mortimer-Filkins Test.

All of these instruments are intended to provide an objective evaluation of the DUI offender with special reference to the drinking behavior. The use of such objective instruments is far superior to a more subjective and potentially biased individual impression. All of these instruments do depend, however, on a degree of accuracy and truthfulness on the part of the interviewee. ***In order to obtain some degree of standardization throughout the Commonwealth, it has been strongly recommended that the Mortimer-Filkins Test be adopted as the routine testing measure for countermeasures programs.***

2) ***Additional Evaluative Indicators*** – There are several supplementary tools that may increase the predictive and diagnostic qualities of the primary measurement instrument. These are as follows:

a) ***Blood Alcohol Concentration (B.A.C.)*** – This is calculated from a measurement of the alcohol content of a sample of expired air from the offender. There is a predictable and constant ratio between the alcohol level in the blood and that in the alveolar air of a subject. It should be noted that a BAC of more than 0.10% in a routine examination is regarded by the Criteria Committee of the National Council on Alcoholism as being clearly and definitely associated with alcoholism. This would imply that every offender arrested for DUI at 0.10% should be considered in a category of alcoholism unless proven otherwise by additional considerations. On this basis, it would certainly seem reasonable to suppose that any person who has been arrested with a BAC of 0.15% or more could be automatically regarded as a serious "problem drinker" or "alcoholic person."

b) ***Previous Arrest Record*** – Any previous arrest for DUI or other alcohol-related offense within the preceding five years should be regarded with a high index of suspicion as suggestive of an "alcoholic person."

c) ***Self Admitted Problem*** – A person voluntarily admitting to "loss of control" over alcohol consumption would lend strong suspicion to the diagnosis of alcoholism.

d) ***Previous Treatment for Alcoholism or Social Problems Related to Alcohol Use*** – A person's self-described or known history of any alcohol-related medical, psychological, or social condition should also be regarded as extremely significant in the diagnosis of alcoholism.

e) ***Measurement of Client Truthfulness*** – It is reasonable to suppose that some of the information obtained from DUI clients may be inaccurate. This could result from deliberate attempts to mislead the interviewer, or in the case of serious alcohol dependency, organic impairment of the brain producing amnesia, alcoholic "blackouts," or inaccurate recall. It is also commonly accepted that many "alcoholic persons" develop extreme denial mechanisms regarding their drinking behaviors and their significance. A number of aids to assess "lie factors" are available. The "Alco-Calculator" can be used to compare police-reported BAC with the client's report of the number of drinks consumed prior to arrest. Should there be a marked discrepancy one can assume misreporting. The ***Eysenck Personality Inventory*** (E.P.I.), a quick and simply administered and scored instrument, has a

specific built in measure of "faking good" responses, and could be incorporated into the interviewer's overall perception of "truthfulness."

Staff Qualifications in the Evaluation Process

Special attention should be paid to the qualifications and characteristics of staff persons selected to conduct and report on evaluations of DUI clients.

The following interviewer characteristics should be sought:

1) Should have received basic training in the areas of alcohol abuse, alcoholism, and highway safety;

2) Reading, writing, and sufficient mathematical skills and verbal communication abilities to prepare reports;

3) Ability to follow standardized directions and procedures;

4) Empathic and sensitive to the population served;

5) Sensitive to the need for, and accountable to, requirements for record confidentiality;

6) Where conditions indicate, a second language may be necessary.

VI. Collection and Utilization of Diagnostic Findings – DUI Countermeasures Summary Report

Upon interview completion and the assembly of relevant informational elements, it will then be necessary to compile a summary report containing three major sections: a diagnostic description of suspected degree of alcoholism; a profile of the offender; and recommendations for follow up and disposition.

It must be strongly emphasized at this point that the accuracy of any report is strongly influenced by the quality of the data that is incorporated in its construction. The computer programmer's adage "GIGO" ("garbage in, garbage out") is an especially important consideration for all programs. If any program of alcohol countermeasures is to succeed, it must have an extremely high level of credibility among all levels of the community, from the DUI offender to the highest court official. Therefore, it must be assumed that all elements of data is meticulously protected to insure that every item, from police Breathalyzer report, to the signature on the final report, is objective, accurate, and free from any personal or subjective influences.

While the degree of objectivity of any program that attempts to incorporate highly selective and isolated behavioral events in making a prediction about a person can certainly be attacked as lacking in total scientific validity, it must be argued that successful rehabilitation (and thus prevention) has been reported in some circumstances to be as high as 80% of the cases treated for alcoholism from less impaired groups in industrial settings. This can be contrasted to a California study that showed as many as two-thirds of drivers with revoked licenses (a non-treatment alternative) were known to continue to drive, since they were identified through subsequent arrests or accidents for driving while under revocation.

Thus, in the absence of complete, and all-encompassing accuracy, it does appear that an identification and rehabilitation process would be no less effective than the present maximum license penalty under the Pennsylvania Motor Vehicle Code.

The content of the DUI Countermeasures Diagnostic Report must contain not only several objective controls, but must also be prepared with a consideration of the priorities and needs of the prospective users of the report, and recognition of the various resources available in the offender's community. Therefore, it is recommended that a "matrix" of events be considered in the analysis of various examination elements before planning for intervention/rehabilitation of each person. A sample of this type of analysis is presented below. This matrix might include some of the following items and would, of course, be best designed and tailored to the major demands and concerns of the local countermeasures program.

	Clinical Diagnostic Indicators:		
Dimension	May Not Be A Problem Drinker	Highly Presumptive Evidence of Problem Drinking	Nearly Certain Evidence of Problem Drinking
1) Mortimer-Filkins			
- Questionnaire	11 or less	12-15	16 or more
- Interview	24 or less	25-39	40 or more
- Total Score	39 or less	40-49	50 or more
2) Blood Alcohol Concentration	0.05% to 0.09%	0.10% to 0.19%	0.20% or more
3) Previous DUI Arrest	0	1-2	3+
4) Previous Alcohol Related Arrest	0	1-2	3+
5) Reliability of Information			
- Alco-Calculator to BAC	Consistent	Inconsistent	Extremely Unlikely
- E.P.I. (Form A or B)	0-3	4 or 5	6 or more
6) NCA Diagnostic Criteria	Etc.	Etc.	Etc.
7) Etc., etc.	Etc.	Etc.	Etc.

It should be stressed that this matrix and all other such reporting documents must be individually summarized, with only essential and relevant information contained within it. It would be highly unlikely that the total folder of all information in unedited fashion would serve the future user in any significant way. What is most important, is that the findings of the diagnostic procedure should be presented in a clear, brief, and concise fashion. Standardized reporting formats are usually very acceptable to judges, probation officers, and treatment staff. However, special care should be given to avoid highly subjective terms in these reports which carry strong emotional or stereotypical loadings such as "skid row type," "dignified businessman," "weekend boozer," and the like.

Qualifying statements such as, "it is the impression of the Countermeasures Diagnostic staff, that in view of this person's self-reports, and the available evidence, such conditions are frequently found in persons showing (no/highly presumptive/nearly certain) evidence of problem drinking," are very important ingredients in the preparation of such reports. It is the only "fair" statement that can be made from such a limited inquiry and thus avoids sweeping generalizations and potentially damning and/or incorrect conclusions. It must always be remembered that such reports and conclusions are subject to judicial review and must ultimately be reasonable and acceptable to the judge and to the offender if the rehabilitation plan is ever to be accepted. At the same time, it is of equal importance to conduct the most comprehensive and intensive investigation of client behaviors that the state of the art will permit. Therefore, by reviewing and investigating both the offender's official report file, and personally examining the individual, a reasonable estimate of the presence of, suspicion of, or absence of alcoholism can be made by an experienced interviewer.

A personal profile of the offender must be included in the formal summary and should be used throughout the various stages of report construction to be sure that no confusion or error is made in the assembly of all data elements. Key identifiers are always included in the personal profile and should always include name, date of birth, address, date and time of arrest, B.A.C. at arrest/retest, time of B.A.C., police I.D. number, previous arrest summary, disposition of previous DUI offenses, employment status, marital status and number of dependents, race, and any other significant identifier available in the countermeasures area that will assist in preventing confusion or possible mistakes in data collection and record review.

Very specific recommendations for follow up should be included at the conclusion of the summary report. These conclusions should be aimed closely at achieving three major goals. These are:

1) Prevention of further DUI behavior through education and rehabilitation.
2) Alerting judges, probation officers, and treatment staff of the significant ingredients in the offender's history to assist their understanding of the case.
3) Assisting the referral process by specifying distinct types of treatment, or services needed that "fit" the individual's needs and the treatment resources of the local community.

There are several underlying assumptions that must be made in any recommendation to send a person for treatment for alcoholism. Many of these are commonly accepted by most persons, but several are quite controversial even among very knowledgeable alcoholism professionals. Few will argue that many persons appear to have problems in maintaining control

over their use of alcohol. It is also commonly accepted that this "loss of control" phenomenon is not absolute, and varies in degree among different individuals and from time to time. The causes of alcoholism and a singularly successful cure have not been determined at this time. It has been the experience of many persons, both recovering alcoholics themselves, and professionals within the treatment community, that alcoholism can be "treated" with reasonable success and that the symptoms that surround it can be significantly reduced in many cases.

Care must also be taken that no confusion is made in understanding that ***remission of symptoms*** is ***not the same as a cure.*** The Governor's Council on Drug and Alcohol Abuse, as well as numerous other national figures and authorities in the field, concede that, at this time, most forms of alcoholism must be considered to be a life-long condition, and numerous relapses and vehement denial are outstanding characteristics of the condition. Thus, many claims of various proponents of specific and universal "cures" must always be regarded with extreme suspicion by any referring agent. However, many techniques and therapies are quite effective for certain persons when they correspond to their ideals and acceptance levels and significant changes in behavior can frequently be expected when conditions are suitable for such changes.

VII. Current Treatment for DUI Offenders in the Commonwealth and Recommendations for Program Development

So far as is known, there are few organized and coordinated systematic treatment programs for DUI offenders in Pennsylvania. In the City of Philadelphia, as a result of some basic research and experience, a need was demonstrated for a treatment program specially designed for problem drinkers in this population, and in 1976 four such special treatment programs are in existence. Also, in Reading, a need for treatment services was recognized, but because of the relatively small number of offenders, their objectives were accomplished within the structure of existing alcoholism treatment programs. In both these cities, the identification and evaluation of the DUI population has resulted in very substantial increases in the referral and admission of alcoholic persons to these alcoholism facilities. In most of Pennsylvania however, there is not only a paucity of alcoholism treatment services in general, but a critical shortage of services for specific groups of alcoholic patients, such as alcoholic DUI offenders.

Throughout the Commonwealth there is a limited number of Alcohol Highway Safety Countermeasures Programs, but the few existing programs are, in nearly all cases, essentially educational in nature and do not emphasize, nor conduct, specific treatment on a formal basis. If treatment is mentioned at all it is within the context of a group experience and it is invariably simply a referral or suggestion to attend an Alcoholics Anonymous open meeting, which for most DUI offenders, who are earlier stage problem drinkers, may be an inappropriate modality. This is partly because of the anonymity required within the organization itself, which, by organizational philosophy, prohibits developing an accurate recording and reporting between the Alcoholics Anonymous groups and the criminal justice system.

Another problem is that most existing alcoholism treatment systems emphasize inpatient treatment, which does not seem to be the most appropriate environment for the vast majority of the alcoholic DUI offenders. The experience of pilot and developing programs strongly supports the notion that these persons require outpatient approaches that are specially tailored to their needs. Treatment programs for these persons will have to relate to the special conditions of this group that reflect their special characteristics and needs.

Current research with the DUI population suggests that these persons are, generally speaking, less alcohol-impaired than the type of patient usually seen in alcoholism treatment programs. They are typically male, more often married and living with their spouses, more likely to have good employment records with continuous employment, and have shorter histories of problem drinking than customarily seen in generally voluntary admissions to alcoholism treatment. Although these characteristics would suggest a better prognosis, they are counterbalanced by a significantly poorer motivation to attend and commit oneself to an enduring treatment plan. It is, therefore, very important that a treatment program become mandatory and that the full support of the criminal justice and probation systems be mobilized to ensure offender participation in treatment.

The results of a pilot demonstration program for alcoholic DUI offenders conducted in Philadelphia in 1975, suggested that, for meaningful behavior changes to occur, once weekly treatment for six months is the minimum involvement, and it would probably be more desirable to insist on approximately one year of weekly therapy sessions to more fully implement significant, long-lasting behavior changes.

There is also a critical need to provide appropriate training for Alcoholism Treatment personnel who are to be involved with the alcoholic DUI offender. They must be made fully aware of the total system in which they are to operate. This means that at least part of their training should occur in association with staff of other components of the Pennsylvania Alcohol-Highway Safety Program. This includes police, probation officers, judges, educators, and administrative officials who each contribute to a comprehensive program of this nature. There are significant differences in the treatment approaches that one might have to adopt for the alcoholic DUI offender than with other kinds of alcoholic populations. The relatively early stages of alcoholism that are characteristic of this group imply that the "rock bottom" approach may not only be inappropriate, but also counter-therapeutic, in the sense that one may be introducing a damaging self-fulfilling prophesy. It has been unfortunately the case in our culture that most alcoholic patients have not entered treatment until there has been significant social and physical deterioration. Therefore, the traditional approaches which might apply to this latter category of alcoholic patient might not be indicated or necessary for these persons arrested for DUI. This implication must be included in any training program where an approach based on the availability of multiple treatment modalities, used in flexible combinations, should be emphasized.

Any treatment program for alcoholic DUI offenders should be seen as an integral part of a total system, under the control and leadership of a single local coordinating authority. The treatment system must link with, and provide continuity of care between, the judicial, probation and parole, and educational components, and should also be closely allied to existing alcohol and general health care delivery systems. There are many different ways

in which this could be accomplished, and in each community the DUI treatment system should become part of the local health care delivery system with special ties to both Drug and Alcohol, and Mental Health Programs. The vitally important part played by the local criminal justice system, which will include police, judges, prosecutors, defenders, and probation and parole officers cannot be overemphasized. ***It is strongly recommended that a specific training program involving all these multidisciplinary components should be organized by any community interested in developing an alcohol highway safety countermeasures program, and should occur at the earliest possible stage of program development.***

VIII. Past, Present, and Future Directions for DUI Countermeasures

Over the past 80 years of driving legislation, there have been few attempts to legislate drunk driving prevention into the Motor Vehicle Code of Pennsylvania.

The Federal Government and the United States Department of Transportation have for many years studied the problem of drunk driving, and after the preparation of a special report to Congress in 1968, made several significant recommendations designed to improve prevention in this area. These recommendations were included in the model traffic code known as the Uniform Motor Vehicle Code which has served as the base for the newly enacted Pennsylvania Motor Vehicle Code of 1976, which significantly updates the law in nearly all aspects of traffic safety.

It is now apparent that a more balanced approach to the problem will be adopted, with the recognition that the criminal justice system and the treatment and rehabilitation system must become partners in any meaningful efforts to reduce the effects of this major public health problem.

Some technological developments are sure to have a marked effect on drunk driving detection and rehabilitation in the coming decade. Portable pre-arrest screening devices are already perfected for police patrol and when such easily utilized instruments are in the hands of the law enforcement officers, a major obstacle to initial identification of the drunken driver will be overcome. The increased organization and standardization of DUI countermeasures in Pennsylvania is sure to have a marked effect on the development of improved administrative and clinical procedures in the management of the problem. Some possible approaches in treatment would include mandatory disulfiram therapy for repeat or resistant offenders, increased use of weekend or evening incarceration, and extensive use of Accelerated Rehabilitative Disposition (A.R.D.). Also, the use of sophisticated breath analysis techniques should be encouraged in all programs involved in evaluation, treatment, and rehabilitation of selected DUI offenders. Such technology will help to refine diagnosis, and objectify and standardize alcohol abuse behaviors. This will facilitate clear communication and therefore foster relationships between rehabilitation staff and the DUI offender. Technology advances are especially important in the use of accurate and understandable measures of condition and progress shared by the therapist with the client.

Of great significance is the growing emphasis on the quality of alcoholism treatment facilities themselves. Standards for operation and licensing as well as national accreditation for alcoholism treatment programs are now a reality. It is also apparent that this process

will accelerate the demise of many marginal and ineffective programs and encourage high administrative and clinical standards for the surviving few. Any form of national health insurance is sure to be linked to the most advanced treatment systems, and payment for any such services will certainly be associated with accredited programs with strong out-patient and aftercare element.

IX. Program Interrelationships

While there are clearly differences in programs operating within the various communities in the Commonwealth, it is apparent that some basic elements must always exist in order to conduct any effective countermeasures program; simply stated, they are law enforcement, judiciary, and rehabilitation. The following flowchart is provided to give a graphic illustration of a fully functioning and comprehensive countermeasures program in the Commonwealth of Pennsylvania.

PENNSLYVANIA ALCOHOL-HIGHWAY SAFETY PROGRAM (PAHSP)

FLOWCHART

I. LAW ENFORCEMENT SECTOR

IA. Arrest Process

II. JUDICIAL SECTOR

IIA. District Attorney Pre-Trial Screening

IIB. Trial Proceedings

IIC. Post-Diagnostic Court Ruling

III. REHABILITATION SECTOR

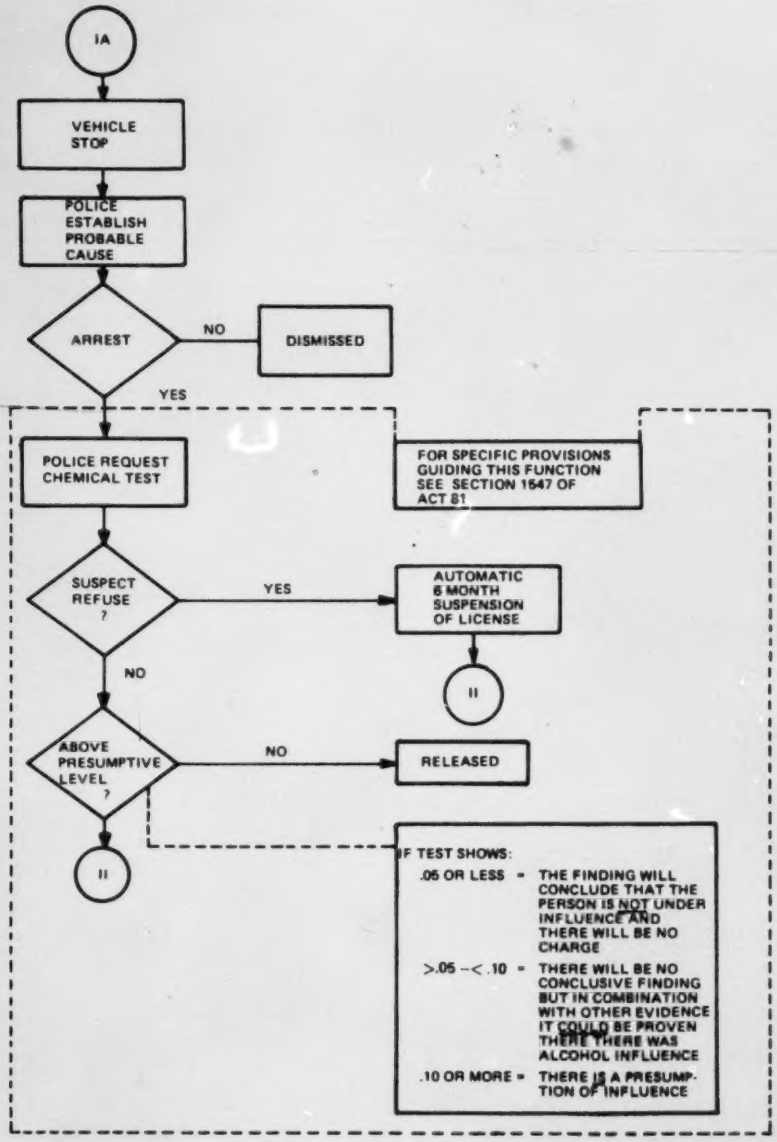
IIIA. Diagnostic Evaluation

IIIB. Psycho-Medical Treatment

IIIC. PAHSP Safe Driving School

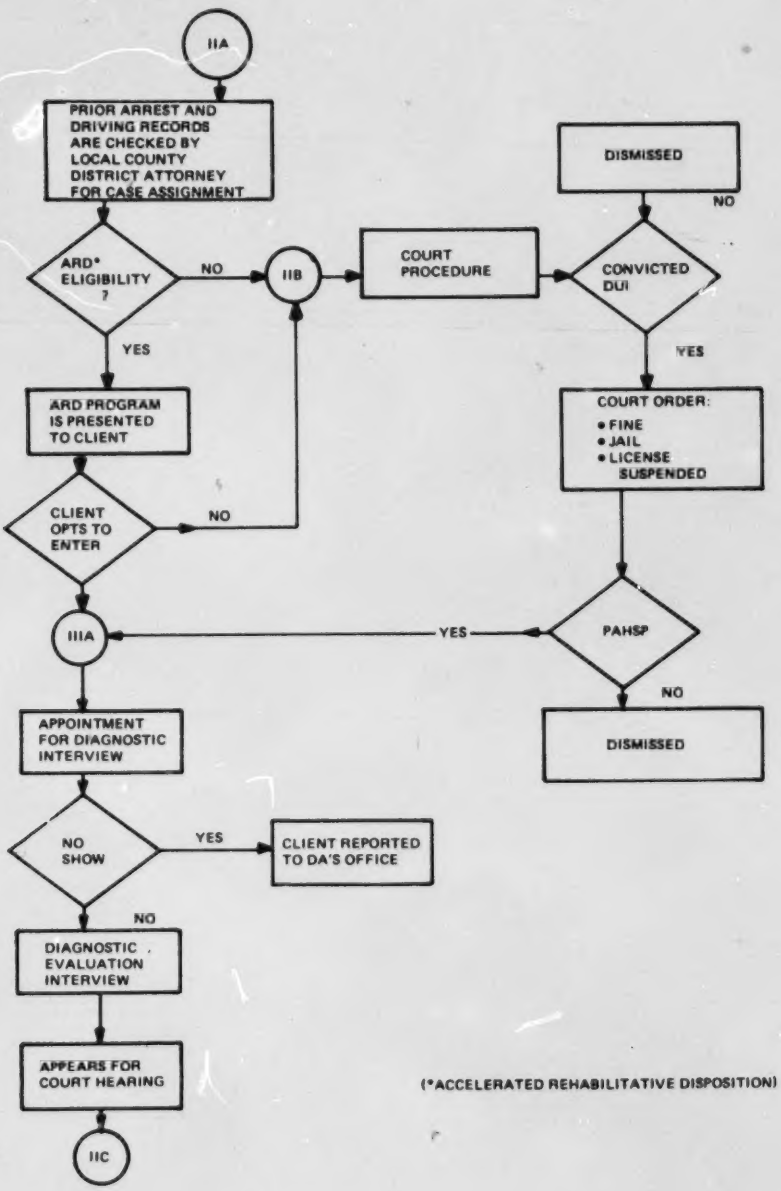
PAHSP - FLOWCHART (1)

I. LAW ENFORCEMENT SECTOR


IA
VEHICLE STOP
POLICE ESTABLISH PROBABLE CAUSE
ARREST
NO
DISMISSED
YES
POLICE REQUEST CHEMICAL TEST
FOR SPECIFIC PROVISIONS GUIDING THIS FUNCTION SEE SECTION 1547 OF ACT 81
SUSPECT REFUSE ?
YES
AUTOMATIC 6 MONTH SUSPENSION OF LICENSE
II
NO
ABOVE PRESUMPTIVE LEVEL ?
NO
RELEASED
II
IF TEST SHOWS:
.05 OR LESS = THE FINDING WILL CONCLUDE THAT THE PERSON IS NOT UNDER INFLUENCE AND THERE WILL BE NO CHARGE
>.05 –< .10 = THERE WILL BE NO CONCLUSIVE FINDING BUT IN COMBINATION WITH OTHER EVIDENCE IT COULD BE PROVEN THERE THERE WAS ALCOHOL INFLUENCE
.10 OR MORE = THERE IS A PRESUMPTION OF INFLUENCE

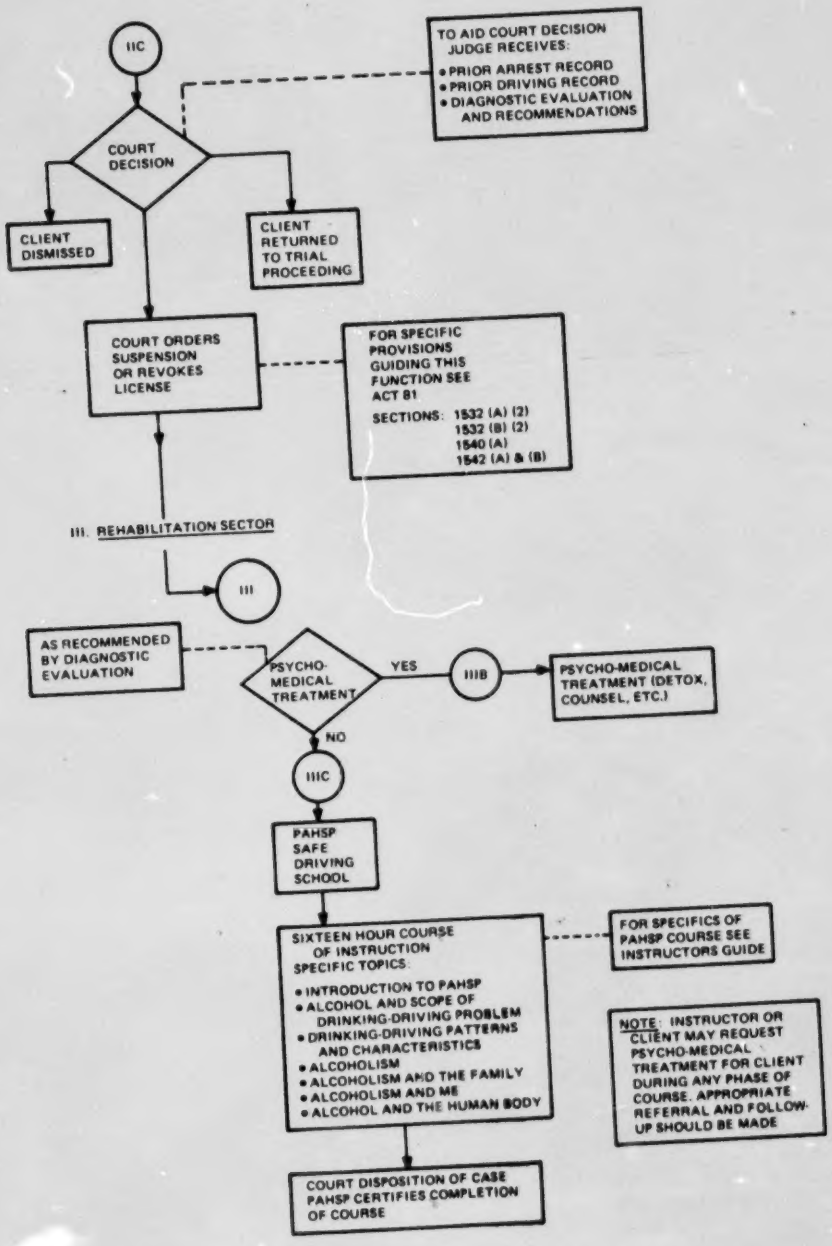
PAHSP - FLOWCHART (2)

II. JUDICIAL SECTOR



(*ACCELERATED REHABILITATIVE DISPOSITION)

PAHSP - FLOWCHART (3)


IIC
TO AID COURT DECISION JUDGE RECEIVES:
• PRIOR ARREST RECORD
• PRIOR DRIVING RECORD
• DIAGNOSTIC EVALUATION AND RECOMMENDATIONS
COURT DECISION
CLIENT DISMISSED
CLIENT RETURNED TO TRIAL PROCEEDING
COURT ORDERS SUSPENSION OR REVOKES LICENSE
FOR SPECIFIC PROVISIONS GUIDING THIS FUNCTION SEE ACT 81
SECTIONS: 1532 (A) (2)
1532 (B) (2)
1540 (A)
1542 (A) & (B)
III. REHABILITATION SECTOR
III
AS RECOMMENDED BY DIAGNOSTIC EVALUATION
PSYCHO-MEDICAL TREATMENT
YES
IIIB
PSYCHO-MEDICAL TREATMENT (DETOX, COUNSEL, ETC.)
NO
IIIC
PAHSP SAFE DRIVING SCHOOL
SIXTEEN HOUR COURSE OF INSTRUCTION SPECIFIC TOPICS:
• INTRODUCTION TO PAHSP
• ALCOHOL AND SCOPE OF DRINKING-DRIVING PROBLEM
• DRINKING-DRIVING PATTERNS AND CHARACTERISTICS
• ALCOHOLISM
• ALCOHOLISM AND THE FAMILY
• ALCOHOLISM AND ME
• ALCOHOL AND THE HUMAN BODY
FOR SPECIFICS OF PAHSP COURSE SEE INSTRUCTORS GUIDE
NOTE: INSTRUCTOR OR CLIENT MAY REQUEST PSYCHO-MEDICAL TREATMENT FOR CLIENT DURING ANY PHASE OF COURSE. APPROPRIATE REFERRAL AND FOLLOW-UP SHOULD BE MADE
COURT DISPOSITION OF CASE PAHSP CERTIFIES COMPLETION OF COURSE

X. The Role of County Officials in the Pennsylvania Alcohol-Highway Safety Program

County officials are among the most important initiators and means of implementation for programs designed to protect society from the drunk driver. Most local officials have become quite aware of the need for advice and funding from the Pennsylvania Department of Transportation offices where highway and highway safety issues are involved. A mechanism already exists within a specific section of the Pennsylvania Department of Transportation that relates itself to alcohol and highway safety. This section, the ***Highway Safety Group***, has selected staff and program managers that are particularly aware of the funding and program necessities in developing local programs. It is also of potentially useful knowledge to consider assistance from Federal funds (known as 402 grants) in initiating new programs in Alcohol Highway Safety. These applications must also be handled through the Pennsylvania Department of Transportation.

The intent of this manual is to once again highlight the serious impact that the drunk driver has on the health of the community. Details are provided here concerning the loss of human life, the crippling injuries, and the tremendous financial cost of drunk driving. These facts should further stimulate those persons elected by their community to do everything in their power that will result in the most effective alcohol highway safety countermeasures effort possible.

The very minimal effort needed by the counties in this ***critically important area*** is an Educational Safe Driving School directly related to the courts. The present intent of the Pennsylvania Department of Transportation and The Governor's Council on Drug and Alcohol Abuse is to encourage every county to utilize reasonably standard basic court and educational procedures. A 16 hour, 8 session course specially designed for the needs of a drunk driving offender has been developed by the Commonwealth of Pennsylvania and it is hoped that this will be adopted throughout the Commonwealth in each county. Copies of this curriculum are available through the Pennsylvania Department of Transportation and The Governor's Council on Drug and Alcohol Abuse and it is anticipated that a special training program for its institution will be organized early in 1977.

Alcohol countermeasures programs in the specific counties will require a maximum degree of local input, and will, therefore, be unique to each county and its needs. Such diversity of programming is healthy but can relate to reasonable standards across the Commonwealth, which will be to their advantage.

XI. Need for DUI Countermeasures in the Budget – A Prevention Tool

Although the overall costs of a fully comprehensive DUI Countermeasures Program might appear high for new programs, one should approach this issue with two special considerations in mind.

First, the bulk of ***new services*** should be largely ***self-supporting***, and ***second***, the potential benefit to the citizens by the "ripple effect" could be profound in human and budgetary terms also.

It is especially pertinent to the issue of DUI that these persons are typically at the early stages of alcoholism and extremely high risk candidates for later, more serious consequences of their condition. There is voluminous evidence available that suggests the types of costs that counties absorb, directly and indirectly, from the alcoholic persons residing in the county. Some of these costs are defined in the terms of Business (average 22 more absences per year than non-alcoholics, double the accident rate), Jail (up to 50% of the inhabitants may be alcoholic persons), Social Welfare (1/4 to 1/3 of assistance to families with dependent children funds are paid to households with alcohol problems), Drug Abuse (abnormally high rates of juvenile drug abuse in homes with parental alcoholism), Mental Health (1/3 to 1/2 of admissions to state and county hospitals are typically alcohol-related), Fire (up to 80% of fire-related deaths related to alcohol abuse), Health (suicide, accidents, general ill health and excessive hospital usage typify the extremes associated with the alcoholic population).

APPENDIX A

PENNSYLVANIA MOTOR VEHICLE CODE RELATED TO DRINKING & DRIVING (ACT 81)

There are a number of provisions within the Motor Vehicle Code which comprise the Commonwealth's policy addressing the problem of drinking and driving. The following is a summary of the various provisions.

Section 3731 – defines driving under the influence of alcohol or controlled substances as a serious traffic offense. The use of alcohol, controlled substances, or the combination of either to a degree which renders a person incapable of safe driving is prohibited and classified as a third degree misdemeanor. The authorized use of such cannot be used as a defense (i.e., prescription usage); and an officer may arrest if he has reason to suspect alcohol or drug influence.

Section 1532 (a) (2) and Section 1532 (b) (2) – stipulates ***penalties*** to a maximum of $2,500 for violation and conviction under Section 3731. On the first offense conviction the department ***must*** suspend the license for six months. If there is a second conviction within three years, the department ***must*** revoke the license for one year.

Section 1540 (a) – requires in cases of mandatory revocation (as provided above) that the court or the district attorney require surrender of the license, and the commencement date for suspension or revocation begins on the date the license is received by the court or the department.

Section 1534 – allows that Accelerated Rehabilitative Disposition (ARD) be offered for violations of Section 1532, however use of ARD must be considered in determining subsequent suspensions (Section 1539 (c)).

Section 1542 (a) and (b) – defines "***habitual offenders.***" Basically, if a person was convicted of drinking under the influence three times within a five year period, they would be classified as an habitual offender and subject to an automatic five year revocation.

The very specific provisions dealing with driving under the influence are found in Section 1547, 1548 and 1549.

Provisions in those sections are outlined below.

Section 1547 – Chemical Test to Determine Amount of Alcohol:

- Consent to alcohol blood level testing is implicit in holding a license.
- Tests must be administered by physician, technician, or trained police officer.
- If a person refuses to submit to test, the test will not be given but there will be an automatic six months suspension for refusing and an automatic one year suspension for a second refusal.
- Police officer must notify the person of consequences of refusal.

- Results of the test are admissable as evidence in summary or criminal proceedings.
- If tests show:

  .05 or less = the finding will conclude that the person is not under influence and there will be no charge under 3731 (1) (2).

  .06 – .09 = there will be no conclusive finding but in combination and other evidence it could be proven that there was alcohol influence.

  .10 or more = there is a presumption of influence.
- If a person is unable to give enough breath for test, blood may be taken. Same provisions on test results as evidence and for refusals apply for blood tests as for breath tests.
- Person shall be permitted to have the test administered by their personal physician and results are admissable.
- Person may request test if involved in an accident and request is to be honored when possible.
- Persons administering tests and hospitals employing such persons are immune from civil liability.

Section 1548 – Post Conviction Examination for Driving Under Influence:

- Requires the court to conduct a pre-sentencing examination to determine if the person needs treatment for alcohol or drug abuse. If the exam indicates a treatment need then the court may order out patient treatment or commitment to a facility approved by The Governor's Council on Drugs and Alcohol Abuse. The exam is carried under provisions of the MH/MR Act of 1966.
- The pre-sentencing exam applies only to second or subsequent offenses within five years.
- The person may be examined by a doctor of their choice and results may be presented to the court.
- The court may also, upon petition, review the order of commitment.

Section 1549 (b) – Establishment of Schools requires the Department of Transportation in conjunction with The Governor's Council on Drug and Alcohol Abuse to establish and maintain an educational course on the problems of alcohol and driving throughout the Commonwealth.

APPENDIX B

Selected References:

A Study of Prevalence and Intensity of Drug and Alcohol Use in the Commonwealth of Pennsylvania. Project Director, Elliot L. Rubin, Ph.D. Harrisburg: The Governor's Council on Drug and Alcohol Abuse. August 10, 1973.

Alcohol and Alcoholism: Problems, Programs, and Progress. NIMH, NIAAA, DHEW Publication No. (HSM) 72-9127, Revised 1972, Available from the National Clearinghouse for Alcohol Literature and Information (NCALI), P.O. Box 1156, Rockville, Maryland 20850, Phone: (301) 948-4450.

1968 Alcohol and Highway Safety Report: A Study Transmitted by the Secretary of the Department of Transportation to the Congress, in accordance with the Requirements of Section 204 of the Highway Safety Act of 1966, Public Law 89-564. August 1968, U.S. Government Printing Office 1968 (98-1760) Committee Print 90th Congress, 2d Session.

American Medical Association, Committee on Medicolegal Problems. ***Alcohol and the Impaired Driver.*** Chicago: American Medical Association, 1968.

Comprehensive Community Services for Alcoholics, The Williamsburg Papers. February 1969. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, Price 65¢. Limited quantities available free from NCALI.

Erwin, Richard E. ***Defense of Drunk Driving Cases.*** Third Edition. Albany: Matthew Bender, 1971.

Facts About Alcohol and Alcoholism. NIAAA, DHEW Publication (ADM) 75-31, Printed 1974, Reprinted 1975, U.S. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Price 85¢. Stock Number 017-024-00351-4 Catalogue No. HE 208302:F11. Also available free in limited quantities from NCALI.

Fine, E. and P. Scoles, "Alcohol, Alcoholism and Highway Safety." Public Health ***Reviews*** (Israel) 1974, pp. 423-436.

Fine. E., P. Scoles, and M. Mulligan, "Under the Influence...." Public Health Reports, Vol. 90, Sept/Oct. 1975, pp. 424-429.

From Program to People: Towards a National Policy on Alcoholism Services and Prevention. NIAAA, DHEW Publication No. (ADM) 75-155, Printed 1974, available from NCALI.

Highway Safety Program Manual. Department of Transportation, NHTSA. January 1969.

Malfetti, J. and D. Winter. ***Counseling Manual for DWI Counterattack Programs.*** Sponsored by AAA Foundation for Traffic Safety. New York: Teachers College, Columbia University, 1976.

Model Cost Accounting System Manual Multiple Direct Service Volume I. Prepared by John T. Gorby and Associates, Inc., Washington, D.C.: National Institute on Alcohol Abuse and Alcoholism, 1975.

Model Cost Accounting System Manual Multiple Direct Service Volume II. Prepared by John T. Gorby and Associates, Inc., Washington, D.C.: National Institute on Alcohol Abuse and Alcoholism, 1975.

Proceedings of the 6th International Conference on Alcohol, Drugs, and Traffic Safety. Toronto, Canada, September 8-13, 1974. Edited by S. Israelstam and S. Lambert; Addiction Research Foundation of Ontario, 33 Russell Street, Toronto, Canada M5S2S1 (Order No. P-240, Clothbound $30.00).

Rx: First Aid for the Drunken Driver Begins in Your Office: GPO 717-793, Revised June 1973, U.S. Department of Transportation, NHTSA.

Second Special Report to the U.S. Congress on Alcohol and Health from the Secretary of Health, Education and Welfare, Morris E. Chafetz, M.D., Chairman of the Task Force, U.S. Government Printing Office, Washington, D.C. Alcohol and Highway Safety Section, pp. 127-144. Limited quantities available free from NCALI.

Seixas, F. and S. Eggleston (Eds.) ***Work in Progress on Alcoholism.*** New York: Annals of the New York Academy of Sciences, 1976.

Studies on Drinking and Driving," ***Quarterly Journal of Studies on Alcohol, Supplement No. 4,*** May 1968, Selden D. Bacon, Ph.D., Special Edition, available from Editorial Office, Center for Alcohol Studies, Rutgers University, New Brunswick, New Jersey 08903. Single copy cost $4.50.

Traffic Safety 1974. U.S. Department of Transportation, NHTSA. A Report of Activity under the Highway Safety Act of 1966. (DOT-HS-801-699), 1974.

APPENDIX C

Treatment Resources in Pennsylvania

Alcoholism Treatment Facilities Directory, published by Alcohol and Drug Problems Association of North America, 1130 Seventeenth Street N.W., Washington, D.C. 20036. 1-10 copies $7.50 plus 50¢ mailing per copy. While published in 1973, it is the most comprehensive listing of almost all state and local programs available.

Facilities Directories within a specific geographic area should be available at the Office of the Drug and Alcohol Authority for your county which would be listed in the Yellow Pages under Social Services.

Additionally, the Local Council of the National Council on Alcoholism also maintains a resource file on local Alcoholism Treatment Facilities in the Council's area and are listed in the telephone White Pages under National Council on Alcoholism.

If the above resources prove inadequate, The Governor's Council on Drug and Alcohol Abuse maintains an information clearinghouse known as ENCORE (717) 787-9761 located at the Riverside Office Building-One, 2101 North Front Street, Harrisburg, Pennsylvania 17110 for special information.

Additionally, there are four Division Offices located in four regions of Pennsylvania with staff available for special information and counsultation needs. These offices are:

Division Office I

Mr. Jacob Armstrong, Chief
Alcohol Institute
915 Corinthian Avenue
Philadelphia, Pa. 19130
(215) 232-5550

Division Office II

Ms. Camille Fidrych, Chief
43 Main Street
Pittston, Pa. 18640
(717) 655-6801

Division Office III

Ms. Ellen Shoemaker, Chief
Riverside Office Center #2
2101 North Front Street
Harrisburg, Pa. 17120
(717) 783-8307

Division Office IV

Ms. Toni Williams, Chief
3406 Fifth Avenue, 3rd Floor
Pittsburgh, Pa. 15213
(412) 565-5765

APPENDIX D

Pennsylvania Alcohol-Highway Safety Program Judicial, Law Enforcement, Counseling and Rehabilitation, and Education Program Reference List:

All of the Manuals for the Pennsylvania Alcohol-Highway Safety Program can be obtained from the Pennsylvania Department of Transportation – Highway Safety Group:

Pennsylvania Alcohol-Highway Safety Program – Judicial Manual: Philadelphia; Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

Pennsylvania Alcohol-Highway Safety Program – Law Enforcement Manual: Philadelphia: Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

Pennsylvania Alcohol-Highway Safety Program – Counseling and Rehabilitation Manual: Philadelphia: Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

Pennsylvania Alcohol-Highway Safety Program – Pennsylvania DUI Safe Driving School – Instructors Guide: Philadelphia: Leiss Lithographers Press, 1976;

Prepared for the Pennsylvania Department of Transportation and the Commonwealth of Pennsylvania Governor's Council on Drug and Alcohol Abuse.

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